

1 AN ACT concerning public aid.

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

4 Section 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.

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

18 (5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

19 Sec. 5-45. Emergency rulemaking.

20 (a) "Emergency" means the existence of any situation that
21 any agency finds reasonably constitutes a threat to the public

1 interest, safety, or welfare.

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

19 (c) An emergency rule may be effective for a period of not
20 longer than 150 days, but the agency's authority to adopt an
21 identical rule under Section 5-40 is not precluded. No
22 emergency rule may be adopted more than once in any 24 month
23 period, except that this limitation on the number of emergency
24 rules that may be adopted in a 24 month period does not apply
25 to (i) emergency rules that make additions to and deletions
26 from the Drug Manual under Section 5-5.16 of the Illinois

1 Public Aid Code or the generic drug formulary under Section
2 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii)
3 emergency rules adopted by the Pollution Control Board before
4 July 1, 1997 to implement portions of the Livestock Management
5 Facilities Act, (iii) emergency rules adopted by the Illinois
6 Department of Public Health under subsections (a) through (i)
7 of Section 2 of the Department of Public Health Act when
8 necessary to protect the public's health, (iv) emergency rules
9 adopted pursuant to subsection (n) of this Section, or (v)
10 emergency rules adopted pursuant to subsection (o) of this
11 Section. Two or more emergency rules having substantially the
12 same purpose and effect shall be deemed to be a single rule for
13 purposes of this Section.

14 (d) In order to provide for the expeditious and timely
15 implementation of the State's fiscal year 1999 budget,
16 emergency rules to implement any provision of Public Act 90-587
17 or 90-588 or any other budget initiative for fiscal year 1999
18 may be adopted in accordance with this Section by the agency
19 charged with administering that provision or initiative,
20 except that the 24-month limitation on the adoption of
21 emergency rules and the provisions of Sections 5-115 and 5-125
22 do not apply to rules adopted under this subsection (d). The
23 adoption of emergency rules authorized by this subsection (d)
24 shall be deemed to be necessary for the public interest,
25 safety, and welfare.

26 (e) In order to provide for the expeditious and timely

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

12 (f) In order to provide for the expeditious and timely
13 implementation of the State's fiscal year 2001 budget,
14 emergency rules to implement any provision of this amendatory
15 Act of the 91st General Assembly or any other budget initiative
16 for fiscal year 2001 may be adopted in accordance with this
17 Section by the agency charged with administering that provision
18 or initiative, except that the 24-month limitation on the
19 adoption of emergency rules and the provisions of Sections
20 5-115 and 5-125 do not apply to rules adopted under this
21 subsection (f). The adoption of emergency rules authorized by
22 this subsection (f) shall be deemed to be necessary for the
23 public interest, safety, and welfare.

24 (g) In order to provide for the expeditious and timely
25 implementation of the State's fiscal year 2002 budget,
26 emergency rules to implement any provision of this amendatory

1 Act of the 92nd General Assembly or any other budget initiative
2 for fiscal year 2002 may be adopted in accordance with this
3 Section by the agency charged with administering that provision
4 or initiative, except that the 24-month limitation on the
5 adoption of emergency rules and the provisions of Sections
6 5-115 and 5-125 do not apply to rules adopted under this
7 subsection (g). The adoption of emergency rules authorized by
8 this subsection (g) shall be deemed to be necessary for the
9 public interest, safety, and welfare.

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

22 (i) In order to provide for the expeditious and timely
23 implementation of the State's fiscal year 2004 budget,
24 emergency rules to implement any provision of this amendatory
25 Act of the 93rd General Assembly or any other budget initiative
26 for fiscal year 2004 may be adopted in accordance with this

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

8 (j) In order to provide for the expeditious and timely
9 implementation of the provisions of the State's fiscal year
10 2005 budget as provided under the Fiscal Year 2005 Budget
11 Implementation (Human Services) Act, emergency rules to
12 implement any provision of the Fiscal Year 2005 Budget
13 Implementation (Human Services) Act may be adopted in
14 accordance with this Section by the agency charged with
15 administering that provision, except that the 24-month
16 limitation on the adoption of emergency rules and the
17 provisions of Sections 5-115 and 5-125 do not apply to rules
18 adopted under this subsection (j). The Department of Public Aid
19 may also adopt rules under this subsection (j) necessary to
20 administer the Illinois Public Aid Code and the Children's
21 Health Insurance Program Act. The adoption of emergency rules
22 authorized by this subsection (j) shall be deemed to be
23 necessary for the public interest, safety, and welfare.

24 (k) In order to provide for the expeditious and timely
25 implementation of the provisions of the State's fiscal year
26 2006 budget, emergency rules to implement any provision of this

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

18 (1) In order to provide for the expeditious and timely
19 implementation of the provisions of the State's fiscal year
20 2007 budget, the Department of Healthcare and Family Services
21 may adopt emergency rules during fiscal year 2007, including
22 rules effective July 1, 2007, in accordance with this
23 subsection to the extent necessary to administer the
24 Department's responsibilities with respect to amendments to
25 the State plans and Illinois waivers approved by the federal
26 Centers for Medicare and Medicaid Services necessitated by the

1 requirements of Title XIX and Title XXI of the federal Social
2 Security Act. The adoption of emergency rules authorized by
3 this subsection (l) shall be deemed to be necessary for the
4 public interest, safety, and welfare.

5 (m) In order to provide for the expeditious and timely
6 implementation of the provisions of the State's fiscal year
7 2008 budget, the Department of Healthcare and Family Services
8 may adopt emergency rules during fiscal year 2008, including
9 rules effective July 1, 2008, in accordance with this
10 subsection to the extent necessary to administer the
11 Department's responsibilities with respect to amendments to
12 the State plans and Illinois waivers approved by the federal
13 Centers for Medicare and Medicaid Services necessitated by the
14 requirements of Title XIX and Title XXI of the federal Social
15 Security Act. The adoption of emergency rules authorized by
16 this subsection (m) shall be deemed to be necessary for the
17 public interest, safety, and welfare.

18 (n) In order to provide for the expeditious and timely
19 implementation of the provisions of the State's fiscal year
20 2010 budget, emergency rules to implement any provision of this
21 amendatory Act of the 96th General Assembly or any other budget
22 initiative authorized by the 96th General Assembly for fiscal
23 year 2010 may be adopted in accordance with this Section by the
24 agency charged with administering that provision or
25 initiative. The adoption of emergency rules authorized by this
26 subsection (n) shall be deemed to be necessary for the public

1 interest, safety, and welfare. The rulemaking authority
2 granted in this subsection (n) shall apply only to rules
3 promulgated during Fiscal Year 2010.

4 (o) In order to provide for the expeditious and timely
5 implementation of the provisions of the State's fiscal year
6 2011 budget, emergency rules to implement any provision of this
7 amendatory Act of the 96th General Assembly or any other budget
8 initiative authorized by the 96th General Assembly for fiscal
9 year 2011 may be adopted in accordance with this Section by the
10 agency charged with administering that provision or
11 initiative. The adoption of emergency rules authorized by this
12 subsection (o) is deemed to be necessary for the public
13 interest, safety, and welfare. The rulemaking authority
14 granted in this subsection (o) applies only to rules
15 promulgated on or after the effective date of this amendatory
16 Act of the 96th General Assembly through June 30, 2011.

17 (p) In order to provide for the expeditious and timely
18 implementation of the provisions of this amendatory Act of the
19 97th General Assembly, emergency rules to implement any
20 provision of this amendatory Act of the 97th General Assembly
21 may be adopted in accordance with this subsection (p) by the
22 agency charged with administering that provision or
23 initiative. The 150-day limitation of the effective period of
24 emergency rules does not apply to rules adopted under this
25 subsection (p), and the effective period may continue through
26 June 30, 2013. The 24-month limitation on the adoption of

1 emergency rules does not apply to rules adopted under this
2 subsection (p). The adoption of emergency rules authorized by
3 this subsection (p) is deemed to be necessary for the public
4 interest, safety, and welfare.

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

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

9 (20 ILCS 415/4d) (from Ch. 127, par. 63b104d)

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

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

1 thereof shall be exempt from jurisdiction B. This paragraph
2 is subject to such modifications or waiver of the
3 exemptions as may be necessary to assure the continuity of
4 federal contributions in those agencies supported in whole
5 or in part by federal funds.

6 (2) The resident administrative head of each State
7 charitable, penal and correctional institution, the
8 chaplains thereof, and all member, patient and inmate
9 employees are exempt from jurisdiction B.

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

21 (4) All beauticians and teachers of beauty culture and
22 teachers of barbering, and all positions heretofore paid
23 under Section 1.22 of "An Act to standardize position
24 titles and salary rates", approved June 30, 1943, as
25 amended, shall be exempt from jurisdiction B.

26 (5) Licensed attorneys in positions as legal or

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

16 (6) All positions established outside the geographical
17 limits of the State of Illinois to which appointments of
18 other than Illinois citizens may be made are exempt from
19 jurisdiction B.

20 (7) Staff attorneys reporting directly to individual
21 Commissioners of the Illinois Workers' Compensation
22 Commission are exempt from jurisdiction B.

23 (8) Twenty-one ~~Twenty~~ senior public service
24 administrator positions within the Department of
25 Healthcare and Family Services, as set forth in this
26 paragraph (8), requiring the specific knowledge of

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

17 (A) HEALTHCARE ADMINISTRATION.

18 Medical Director: Licensed Medical Doctor in
19 good standing; experience in healthcare payment
20 systems, pay for performance initiatives, medical
21 necessity criteria or federal or State quality
22 improvement programs; preferred experience serving
23 Medicaid patients or experience in population
24 health programs with a large provider, health
25 insurer, government agency, or research
26 institution.

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

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

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

21 Director of Care Coordination Contracts and
22 Compliance: Bachelor's degree required; multi-year
23 experience in negotiating managed care contracts,
24 preferably on behalf of a payer; experience with
25 health care contract compliance.

26 Manager, Long Term Care Policy: Bachelor's

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

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

24 ~~Chief, Bureau of Pharmacy Services: Bachelor's~~
25 ~~degree required; pharmacy degree preferred; in~~
26 ~~formulary development and management from both a~~

1 ~~clinical and financial perspective, experience in~~
2 ~~prescription drug utilization review and~~
3 ~~utilization control policies, knowledge of retail~~
4 ~~pharmacy reimbursement policies and methodologies~~
5 ~~and available benchmarks, knowledge of Medicare~~
6 ~~Part D benefit design.~~

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

16 Director of Dental Program: Bachelor's degree
17 required, advanced degree preferred, in healthcare
18 management or relevant field; experience in
19 healthcare administration; experience in
20 administering dental healthcare programs,
21 knowledge of practice standards for dental care
22 and treatment services; knowledge of the public
23 dental health infrastructure.

24 Manager of Medicare/Medicaid Coordination:
25 Bachelor's degree required, knowledge and
26 experience with Medicare Advantage rules and

1 regulations, knowledge of Medicaid laws and
2 policies; experience with contract drafting
3 preferred.

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

16 (B) HEALTHCARE FINANCE.

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

23 Director of Encounter Data Program: Bachelor's
24 degree required, advanced degree preferred,
25 preferably in business or information systems; at
26 least 2 years healthcare data reporting

1 experience, including, but not limited to, data
2 definitions, submission, and editing; strong
3 background in HIPAA transactions relevant to
4 encounter data submission; knowledge of healthcare
5 claims systems.

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

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

23 (C) HEALTHCARE DATA ANALYTICS.

24 Data Quality Assurance Manager: Bachelor's
25 degree required, advanced degree preferred,
26 preferably in business, information systems, or

1 epidemiology; at least 3 years of extensive
2 healthcare data reporting experience with a large
3 provider, health insurer, government agency, or
4 research institution; previous data quality
5 assurance role or formal data quality assurance
6 training.

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

19 Data Analytics Platform Manager: Bachelor's
20 degree required, advanced degree preferred,
21 preferably in business or information systems;
22 extensive healthcare data reporting experience
23 with a large provider, health insurer, government
24 agency, or research institution; previous
25 experience working on a health insurance data
26 analytics platform; experience managing contracts

1 and vendors preferred.

2 (D) HEALTHCARE INFORMATION TECHNOLOGY.

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

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

22 Assistant Bureau Chief, Office of Information
23 Systems: Bachelor's degree required, with
24 preferred coursework in business, public
25 administration, information systems; experience
26 equivalent to 5 years of administration in a public

1 or private business organization; extensive
2 technical writing experience, including, but not
3 limited to, the development of RFPs, APDs,
4 feasibility studies and related documents;
5 extensive healthcare technology experience with a
6 large provider, health insurer, government agency,
7 or research institution; experience as a business
8 analyst interfacing between business and
9 information technology departments; thorough
10 knowledge of IT system design, commercial off the
11 shelf software packages and hardware components.

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

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

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

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

3 (30 ILCS 5/2-20 new)

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

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

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

18 (c) No later than May 1, 2013, the Auditor General shall
19 submit a report to the Governor, the Speaker of the House of
20 Representatives, the Minority Leader of the House of
21 Representatives, the Senate President, and the Senate Minority
22 Leader as to whether the Department has undertaken the required
23 actions listed in the report required by subsection (a).

24 Section 15. The State Finance Act is amended by changing

1 Sections 6z-52 and 13.2 as follows:

2 (30 ILCS 105/6z-52)

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

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

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

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

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

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

25 (4) For payments of operational and administrative

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

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

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

23 (2) All federal matching funds received by the Illinois
24 Department as a result of expenditures made by the
25 Department that are attributable to moneys deposited in the
26 Fund.

1 (3) Any premium collected by the Illinois Department
2 from participants under a waiver approved by the federal
3 government relating to provision of pharmaceutical
4 services.

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

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

9 (30 ILCS 105/13.2) (from Ch. 127, par. 149.2)

10 Sec. 13.2. Transfers among line item appropriations.

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

17 (a-1) No transfers may be made from one agency to another
18 agency, nor may transfers be made from one institution of
19 higher education to another institution of higher education
20 except as provided by subsection (a-4).

21 (a-2) Except as otherwise provided in this Section,
22 transfers may be made only among the objects of expenditure
23 enumerated in this Section, except that no funds may be
24 transferred from any appropriation for personal services, from
25 any appropriation for State contributions to the State

1 Employees' Retirement System, from any separate appropriation
2 for employee retirement contributions paid by the employer, nor
3 from any appropriation for State contribution for employee
4 group insurance. During State fiscal year 2005, an agency may
5 transfer amounts among its appropriations within the same
6 treasury fund for personal services, employee retirement
7 contributions paid by employer, and State Contributions to
8 retirement systems; notwithstanding and in addition to the
9 transfers authorized in subsection (c) of this Section, the
10 fiscal year 2005 transfers authorized in this sentence may be
11 made in an amount not to exceed 2% of the aggregate amount
12 appropriated to an agency within the same treasury fund. During
13 State fiscal year 2007, the Departments of Children and Family
14 Services, Corrections, Human Services, and Juvenile Justice
15 may transfer amounts among their respective appropriations
16 within the same treasury fund for personal services, employee
17 retirement contributions paid by employer, and State
18 contributions to retirement systems. During State fiscal year
19 2010, the Department of Transportation may transfer amounts
20 among their respective appropriations within the same treasury
21 fund for personal services, employee retirement contributions
22 paid by employer, and State contributions to retirement
23 systems. During State fiscal year 2010 only, an agency may
24 transfer amounts among its respective appropriations within
25 the same treasury fund for personal services, employee
26 retirement contributions paid by employer, and State

1 contributions to retirement systems. Notwithstanding, and in
2 addition to, the transfers authorized in subsection (c) of this
3 Section, these transfers may be made in an amount not to exceed
4 2% of the aggregate amount appropriated to an agency within the
5 same treasury fund.

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

14 (a-4) Long-Term Care Rebalancing. The Governor may
15 designate amounts set aside for institutional services
16 appropriated from the General Revenue Fund or any other State
17 fund that receives monies for long-term care services to be
18 transferred to all State agencies responsible for the
19 administration of community-based long-term care programs,
20 including, but not limited to, community-based long-term care
21 programs administered by the Department of Healthcare and
22 Family Services, the Department of Human Services, and the
23 Department on Aging, provided that the Director of Healthcare
24 and Family Services first certifies that the amounts being
25 transferred are necessary for the purpose of assisting persons
26 in or at risk of being in institutional care to transition to

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

13 (b) In addition to the general transfer authority provided
14 under subsection (c), the following agencies have the specific
15 transfer authority granted in this subsection:

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

23 The Department of Children and Family Services is
24 authorized to make transfers not exceeding 2% of the aggregate
25 amount appropriated to it within the same treasury fund for the
26 following line items among these same line items: Foster Home

1 and Specialized Foster Care and Prevention, Institutions and
2 Group Homes and Prevention, and Purchase of Adoption and
3 Guardianship Services.

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

10 The State Treasurer is authorized to make transfers among
11 line item appropriations from the Capital Litigation Trust
12 Fund, with respect to costs incurred in fiscal years 2002 and
13 2003 only, when the balance remaining in one or more such line
14 item appropriations is insufficient for the purpose for which
15 the appropriation was made, provided that no such transfer may
16 be made unless the amount transferred is no longer required for
17 the purpose for which that appropriation was made.

18 The State Board of Education is authorized to make
19 transfers from line item appropriations within the same
20 treasury fund for General State Aid and General State Aid -
21 Hold Harmless, provided that no such transfer may be made
22 unless the amount transferred is no longer required for the
23 purpose for which that appropriation was made, to the line item
24 appropriation for Transitional Assistance when the balance
25 remaining in such line item appropriation is insufficient for
26 the purpose for which the appropriation was made.

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

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

23 (c) The sum of such transfers for an agency in a fiscal
24 year shall not exceed 2% of the aggregate amount appropriated
25 to it within the same treasury fund for the following objects:
26 Personal Services; Extra Help; Student and Inmate

1 Compensation; State Contributions to Retirement Systems; State
2 Contributions to Social Security; State Contribution for
3 Employee Group Insurance; Contractual Services; Travel;
4 Commodities; Printing; Equipment; Electronic Data Processing;
5 Operation of Automotive Equipment; Telecommunications
6 Services; Travel and Allowance for Committed, Paroled and
7 Discharged Prisoners; Library Books; Federal Matching Grants
8 for Student Loans; Refunds; Workers' Compensation,
9 Occupational Disease, and Tort Claims; and, in appropriations
10 to institutions of higher education, Awards and Grants.
11 Notwithstanding the above, any amounts appropriated for
12 payment of workers' compensation claims to an agency to which
13 the authority to evaluate, administer and pay such claims has
14 been delegated by the Department of Central Management Services
15 may be transferred to any other expenditure object where such
16 amounts exceed the amount necessary for the payment of such
17 claims.

18 (c-1) Special provisions for State fiscal year 2003.
19 Notwithstanding any other provision of this Section to the
20 contrary, for State fiscal year 2003 only, transfers among line
21 item appropriations to an agency from the same treasury fund
22 may be made provided that the sum of such transfers for an
23 agency in State fiscal year 2003 shall not exceed 3% of the
24 aggregate amount appropriated to that State agency for State
25 fiscal year 2003 for the following objects: personal services,
26 except that no transfer may be approved which reduces the

1 aggregate appropriations for personal services within an
2 agency; extra help; student and inmate compensation; State
3 contributions to retirement systems; State contributions to
4 social security; State contributions for employee group
5 insurance; contractual services; travel; commodities;
6 printing; equipment; electronic data processing; operation of
7 automotive equipment; telecommunications services; travel and
8 allowance for committed, paroled, and discharged prisoners;
9 library books; federal matching grants for student loans;
10 refunds; workers' compensation, occupational disease, and tort
11 claims; and, in appropriations to institutions of higher
12 education, awards and grants.

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

23 (d) Transfers among appropriations made to agencies of the
24 Legislative and Judicial departments and to the
25 constitutionally elected officers in the Executive branch
26 require the approval of the officer authorized in Section 10 of

1 this Act to approve and certify vouchers. Transfers among
2 appropriations made to the University of Illinois, Southern
3 Illinois University, Chicago State University, Eastern
4 Illinois University, Governors State University, Illinois
5 State University, Northeastern Illinois University, Northern
6 Illinois University, Western Illinois University, the Illinois
7 Mathematics and Science Academy and the Board of Higher
8 Education require the approval of the Board of Higher Education
9 and the Governor. Transfers among appropriations to all other
10 agencies require the approval of the Governor.

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

24 (e) The State Board of Education, in consultation with the
25 State Comptroller, may transfer line item appropriations for
26 General State Aid between the Common School Fund and the

1 Education Assistance Fund. With the advice and consent of the
2 Governor's Office of Management and Budget, the State Board of
3 Education, in consultation with the State Comptroller, may
4 transfer line item appropriations between the General Revenue
5 Fund and the Education Assistance Fund for the following
6 programs:

7 (1) Disabled Student Personnel Reimbursement (Section
8 14-13.01 of the School Code);

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

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

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

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

16 (6) Summer School Payments (Section 18-4.3 of the
17 School Code);

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

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

22 (9) Special Education Reimbursement (Section 14-7.03
23 of the School Code).

24 (Source: P.A. 95-707, eff. 1-11-08; 96-37, eff. 7-13-09;
25 96-820, eff. 11-18-09; 96-959, eff. 7-1-10; 96-1086, eff.
26 7-16-10; 96-1501, eff. 1-25-11.)

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 is experiencing an emergency medical
4 condition or needs active medical monitoring, including
5 isolation precautions, supplemental oxygen that is not
6 self-administered, continuous airway management,
7 suctioning during transport, or the administration of
8 intravenous fluids during transport. ~~He or she is acutely~~
9 ~~ill, wounded, or medically unstable as determined by a~~
10 ~~licensed physician.~~

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

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

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

24 (e) The Stretcher Van Licensure Fund is created as a
25 special fund within the State treasury. All fees received by
26 the Department in connection with the licensure of stretcher

1 van providers under this Section shall be deposited into the
2 fund. Moneys in the fund shall be subject to appropriation to
3 the Department for use in implementing this Section.

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

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

8 (210 ILCS 155/35)

9 Sec. 35. LTAC supplemental per diem rate.

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

13 (1) who upon admission to the LTAC hospital meet LTAC
14 hospital criteria; and

15 (2) whose care is primarily paid for by the Department
16 under Title XIX of the Social Security Act or whose care is
17 primarily paid for by the Department after the patient has
18 exhausted his or her benefits under Medicare.

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

22 (1) the LTAC hospital no longer meets the requirements
23 under Section 15 of this Act or terminates the agreement
24 specified under Section 15 of this Act;

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

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

7 (c) The Department may adjust the LTAC supplemental per
8 diem rate calculated under this Section based only on the
9 conditions and requirements described under Section 40 and
10 Section 45 of this Act.

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

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

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

18 (3) The LTAC hospital's Medicaid Percentage Adjustment
19 (MPA) rate as calculated under 89 Ill. Adm. Code 148.122.

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

23 (e) LTAC supplemental per diem rates ~~are~~ effective July 1,
24 2012 shall be the amount in effect as of October 1, 2010. No
25 new hospital may qualify for the program after the effective
26 date of this amendatory Act of the 97th General Assembly for 12

1 ~~months beginning on October 1 of each year and must be updated~~
2 ~~every 12 months.~~

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

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

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

19 (210 ILCS 155/40)

20 Sec. 40. Rate adjustments for quality measures.

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

24 (b) After the first year of operation of the Program
25 established by this Act, the Department may reduce the LTAC

1 supplemental per diem rate calculated under Section 35 of this
2 Act by no more than 5% for an LTAC hospital that does not meet
3 benchmarks or targets set by the Department under paragraph (2)
4 of subsection (b) of Section 50.

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

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

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

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

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

26 (h) On and after July 1, 2012, the Department shall reduce

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

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

7 (210 ILCS 155/45)

8 Sec. 45. Program evaluation.

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

15 (b) The Department shall consult with ~~and~~ qualified LTAC
16 hospitals to ~~must~~ determine the appropriate methodology to
17 accurately calculate the Program's savings and costs. The
18 calculation shall take into consideration, but shall not be
19 limited to, the length of stay in an acute care hospital prior
20 to transfer, the length of stay in the LTAC taking into account
21 the acuity of the patient at the time of the LTAC admission,
22 and admissions to the LTAC from settings other than an STAC
23 hospital.

24 (c) The evaluation must also determine the effects the
25 Program has had in improving patient satisfaction and health

1 outcomes.

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

13 (e) The rate adjustment described in subsection (d) of this
14 Section, if necessary, shall be applied to the LTAC
15 supplemental per diem rate for the rate year beginning October
16 1, 2014. The Department may apply this rate adjustment in
17 subsequent rate years if the conditions under subsection (d) of
18 this Section are met. The Department must apply the rate
19 adjustment to an individual LTAC hospital's LTAC supplemental
20 per diem rate only in years when the Program evaluation
21 indicates a net cost for the Department.

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

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

1 (210 ILCS 155/55 new)

2 Sec. 55. Demonstration care coordination program for
3 post-acute care.

4 (a) The Department may develop a demonstration care
5 coordination program for LTAC hospital appropriate patients
6 with the goal of improving the continuum of care for patients
7 who have been discharged from an LTAC hospital.

8 (b) The program shall require risk-sharing and quality
9 targets.

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

12 (215 ILCS 106/25)

13 Sec. 25. Health benefits for children.

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

16 (1) Subsidizing the cost of privately sponsored health
17 insurance, including employer based health insurance, to
18 assist families to take advantage of available privately
19 sponsored health insurance for their eligible children;
20 and

21 (2) Purchasing or providing health care benefits for
22 eligible children. The health benefits provided under this
23 subdivision (a)(2) shall, subject to appropriation and

1 without regard to any applicable cost sharing under Section
2 30, be identical to the benefits provided for children
3 under the State's approved plan under Title XIX of the
4 Social Security Act. Providers under this subdivision
5 (a)(2) shall be subject to approval by the Department to
6 provide health care under the Illinois Public Aid Code and
7 shall be reimbursed at the same rate as providers under the
8 State's approved plan under Title XIX of the Social
9 Security Act. In addition, providers may retain
10 co-payments when determined appropriate by the Department.

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

13 (c) The Department is prohibited from denying coverage to a
14 child who is enrolled in a privately sponsored health insurance
15 plan pursuant to subdivision (a)(1) because the plan does not
16 meet federal benchmarking standards or cost sharing and
17 contribution requirements. To be eligible for inclusion in the
18 Program, the plan shall contain comprehensive major medical
19 coverage which shall consist of physician and hospital
20 inpatient services. The Department is prohibited from denying
21 coverage to a child who is enrolled in a privately sponsored
22 health insurance plan pursuant to subdivision (a)(1) because
23 the plan offers benefits in addition to physician and hospital
24 inpatient services.

25 (d) The total dollar amount of subsidizing coverage per
26 child per month pursuant to subdivision (a)(1) shall be equal

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

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

19 (f) In order to accelerate and facilitate the development
20 of networks to deliver services to children in areas outside
21 counties with populations in excess of 3,000,000, in the event
22 less than 25% of the eligible children in a county or
23 contiguous counties has enrolled with a Health Maintenance
24 Organization pursuant to Section 5-11 of the Illinois Public
25 Aid Code, the Department may develop and implement
26 demonstration projects to create alternative networks designed

1 to enhance enrollment and participation in the program. The
2 Department shall prescribe by rule the criteria, standards, and
3 procedures for effecting demonstration projects under this
4 Section.

5 (g) 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 Act or the Illinois
8 Public Aid Code to reduce any rate of reimbursement for
9 services or other payments in accordance with Section 5-5e of
10 the Illinois Public Aid Code.

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

12 (215 ILCS 106/40)

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

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

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

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

25 ~~(c) Eligibility of a person under an approved waiver due to~~

~~the relationship with a child pursuant to Article V of the Illinois Public Aid Code or this Act shall be limited to such a person whose countable income is determined by the Department to be at or below such income eligibility standard as the Department by rule shall establish. The income level established by the Department shall not be below 90% of the federal poverty level. Such persons who are determined to be eligible must reapply, or otherwise establish eligibility, at least annually. An eligible person shall be required, as determined by the Department by rule, to report promptly those changes in income and other circumstances that affect eligibility. The eligibility of a person may be redetermined based on the information reported or may be terminated based on the failure to report or failure to report accurately. A person may also be held liable to the Department for any payments made by the Department on such person's behalf that were inappropriate. An applicant shall be provided with notice of these obligations.~~

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

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

(215 ILCS 170/30)

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

Sec. 30. Program outreach and marketing. The Department may

1 provide grants to application agents and other community-based
2 organizations to educate the public about the availability of
3 the Program. The Department shall adopt rules regarding
4 performance standards and outcomes measures expected of
5 organizations that are awarded grants under this Section,
6 including penalties for nonperformance of contract standards.

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

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

11 (215 ILCS 170/35)

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

13 Sec. 35. Health care benefits for children.

14 (a) The Department shall purchase or provide health care
15 benefits for eligible children that are identical to the
16 benefits provided for children under the Illinois Children's
17 Health Insurance Program Act, except for non-emergency
18 transportation.

19 (b) As an alternative to the benefits set forth in
20 subsection (a), and when cost-effective, the Department may
21 offer families subsidies toward the cost of privately sponsored
22 health insurance, including employer-sponsored health
23 insurance.

24 (c) Notwithstanding clause (i) of subdivision (a)(3) of
25 Section 20, the Department may consider offering, as an

1 alternative to the benefits set forth in subsection (a),
2 partial coverage to children who are enrolled in a
3 high-deductible private health insurance plan.

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

10 (e) The content and availability of benefits described in
11 subsections (b), (c), and (d), and the terms of eligibility for
12 those benefits, shall be at the Department's discretion and the
13 Department's determination of efficacy and cost-effectiveness
14 as a means of promoting retention of private or
15 employer-sponsored health insurance.

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

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

23 Section 75. The Illinois Public Aid Code is amended by
24 changing Sections 3-1.2, 5-2, 5-4, 5-4.1, 5-4.2, 5-5, 5-5.02,
25 5-5.05, 5-5.2, 5-5.3, 5-5.4, 5-5.4e, 5-5.5, 5-5.8b, 5-5.12,

1 5-5.17, 5-5.20, 5-5.23, 5-5.24, 5-5.25, 5-16.7, 5-16.7a,
2 5-16.8, 5-16.9, 5-17, 5-19, 5-24, 5-30, 5A-1, 5A-2, 5A-3, 5A-4,
3 5A-5, 5A-6, 5A-8, 5A-10, 5A-12.2, 5A-14, 6-11, 11-13, 11-26,
4 12-4.25, 12-4.38, 12-4.39, 12-10.5, 12-13.1, 14-8, and 15-1 and
5 by adding Sections 5-2b, 5-2.1d, 5-5e, 5-5e.1, 5-5f, 5A-15,
6 11-5.2, 11-5.3, and 14-11 as follows:

7 (305 ILCS 5/3-1.2) (from Ch. 23, par. 3-1.2)

8 Sec. 3-1.2. Need. Income available to the person, when
9 added to contributions in money, substance, or services from
10 other sources, including contributions from legally
11 responsible relatives, must be insufficient to equal the grant
12 amount established by Department regulation for such person.

13 In determining earned income to be taken into account,
14 consideration shall be given to any expenses reasonably
15 attributable to the earning of such income. If federal law or
16 regulations permit or require exemption of earned or other
17 income and resources, the Illinois Department shall provide by
18 rule and regulation that the amount of income to be disregarded
19 be increased (1) to the maximum extent so required and (2) to
20 the maximum extent permitted by federal law or regulation in
21 effect as of the date this Amendatory Act becomes law. The
22 Illinois Department may also provide by rule and regulation
23 that the amount of resources to be disregarded be increased to
24 the maximum extent so permitted or required. Subject to federal
25 approval, resources (for example, land, buildings, equipment,

1 supplies, or tools), including farmland property and personal
2 property used in the income-producing operations related to the
3 farmland (for example, equipment and supplies, motor vehicles,
4 or tools), necessary for self-support, up to \$6,000 of the
5 person's equity in the income-producing property, provided
6 that the property produces a net annual income of at least 6%
7 of the excluded equity value of the property, are exempt.
8 Equity value in excess of \$6,000 shall not be excluded if the
9 activity produces income that is less than 6% of the exempt
10 equity due to reasons beyond the person's control (for example,
11 the person's illness or crop failure) and there is a reasonable
12 expectation that the property will again produce income equal
13 to or greater than 6% of the equity value (for example, a
14 medical prognosis that the person is expected to respond to
15 treatment or that drought-resistant corn will be planted). If
16 the person owns more than one piece of property and each
17 produces income, each piece of property shall be looked at to
18 determine whether the 6% rule is met, and then the amounts of
19 the person's equity in all of those properties shall be totaled
20 to determine whether the total equity is \$6,000 or less. The
21 total equity value of all properties that is exempt shall be
22 limited to \$6,000.

23 In determining the resources of an individual or any
24 dependents, the Department shall exclude from consideration
25 the value of funeral and burial spaces, ~~grave markers and other~~
26 ~~funeral and burial merchandise,~~ funeral and burial insurance

1 the proceeds of which can only be used to pay the funeral and
2 burial expenses of the insured and funds specifically set aside
3 for the funeral and burial arrangements of the individual or
4 his or her dependents, including prepaid funeral and burial
5 plans, to the same extent that such items are excluded from
6 consideration under the federal Supplemental Security Income
7 program (SSI).

8 Prepaid funeral or burial contracts are exempt to the
9 following extent:

10 (1) Funds in a revocable prepaid funeral or burial
11 contract are exempt up to \$1,500, except that any portion
12 of a contract that clearly represents the purchase of
13 burial space, as that term is defined for purposes of the
14 Supplemental Security Income program, is exempt regardless
15 of value.

16 (2) Funds in an irrevocable prepaid funeral or burial
17 contract are exempt up to \$5,874, except that any portion
18 of a contract that clearly represents the purchase of
19 burial space, as that term is defined for purposes of the
20 Supplemental Security Income program, is exempt regardless
21 of value. This amount shall be adjusted annually for any
22 increase in the Consumer Price Index. The amount exempted
23 shall be limited to the price of the funeral goods and
24 services to be provided upon death. The contract must
25 provide a complete description of the funeral goods and
26 services to be provided and the price thereof. Any amount

1 in the contract not so specified shall be treated as a
2 transfer of assets for less than fair market value.

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

24 Notwithstanding any other provision of this Code to the
25 contrary, an irrevocable trust containing the resources of a
26 person who is determined to have a disability shall be

1 considered exempt from consideration. Such trust must be
2 established and managed by a non-profit association that pools
3 funds but maintains a separate account for each beneficiary.
4 The trust may be established by the person, a parent,
5 grandparent, legal guardian, or court. It must be established
6 for the sole benefit of the person and language contained in
7 the trust shall stipulate that any amount remaining in the
8 trust (up to the amount expended by the Department on medical
9 assistance) that is not retained by the trust for reasonable
10 administrative costs related to wrapping up the affairs of the
11 subaccount shall be paid to the Department upon the death of
12 the person. After a person reaches age 65, any funding by or on
13 behalf of the person to the trust shall be treated as a
14 transfer of assets for less than fair market value unless the
15 person is a ward of a county public guardian or the State
16 guardian pursuant to Section 13-5 of the Probate Act of 1975 or
17 Section 30 of the Guardianship and Advocacy Act and lives in
18 the community, or the person is a ward of a county public
19 guardian or the State guardian pursuant to Section 13-5 of the
20 Probate Act of 1975 or Section 30 of the Guardianship and
21 Advocacy Act and a court has found that any expenditures from
22 the trust will maintain or enhance the person's quality of
23 life. If the trust contains proceeds from a personal injury
24 settlement, any Department charge must be satisfied in order
25 for the transfer to the trust to be treated as a transfer for
26 fair market value.

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

13 Occasional or irregular gifts in cash, goods or services
14 from persons who are not legally responsible relatives which
15 are of nominal value or which do not have significant effect in
16 meeting essential requirements shall be disregarded. The
17 eligibility of any applicant for or recipient of public aid
18 under this Article is not affected by the payment of any grant
19 under the "Senior Citizens and Disabled Persons Property Tax
20 Relief ~~and Pharmaceutical Assistance Act~~" or any distributions
21 or items of income described under subparagraph (X) of
22 paragraph (2) of subsection (a) of Section 203 of the Illinois
23 Income Tax Act.

24 The Illinois Department may, after appropriate
25 investigation, establish and implement a consolidated standard
26 to determine need and eligibility for and amount of benefits

1 under this Article or a uniform cash supplement to the federal
2 Supplemental Security Income program for all or any part of the
3 then current recipients under this Article; provided, however,
4 that the establishment or implementation of such a standard or
5 supplement shall not result in reductions in benefits under
6 this Article for the then current recipients of such benefits.

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

8 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

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

14 1. Recipients of basic maintenance grants under
15 Articles III and IV.

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

1 (a) All persons otherwise eligible for basic
2 maintenance under Article III but who fail to qualify
3 under that Article on the basis of need and who meet
4 either of the following requirements:

5 (i) their income, as determined by the
6 Illinois Department in accordance with any federal
7 requirements, is equal to or less than 70% in
8 fiscal year 2001, equal to or less than 85% in
9 fiscal year 2002 and until a date to be determined
10 by the Department by rule, and equal to or less
11 than 100% beginning on the date determined by the
12 Department by rule, of the nonfarm income official
13 poverty line, as defined by the federal Office of
14 Management and Budget and revised annually in
15 accordance with Section 673(2) of the Omnibus
16 Budget Reconciliation Act of 1981, applicable to
17 families of the same size; or

18 (ii) their income, after the deduction of
19 costs incurred for medical care and for other types
20 of remedial care, is equal to or less than 70% in
21 fiscal year 2001, equal to or less than 85% in
22 fiscal year 2002 and until a date to be determined
23 by the Department by rule, and equal to or less
24 than 100% beginning on the date determined by the
25 Department by rule, of the nonfarm income official
26 poverty line, as defined in item (i) of this

1 subparagraph (a).

2 (b) All persons who, excluding any eligibility
3 requirements that are inconsistent with any federal
4 law or federal regulation, as interpreted by the U.S.
5 Department of Health and Human Services, would be
6 determined eligible for such basic maintenance under
7 Article IV by disregarding the maximum earned income
8 permitted by federal law.

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

11 4. Persons not eligible under any of the preceding
12 paragraphs who fall sick, are injured, or die, not having
13 sufficient money, property or other resources to meet the
14 costs of necessary medical care or funeral and burial
15 expenses.

16 5.(a) Women during pregnancy, after the fact of
17 pregnancy has been determined by medical diagnosis, and
18 during the 60-day period beginning on the last day of the
19 pregnancy, together with their infants and children born
20 after September 30, 1983, whose income and resources are
21 insufficient to meet the costs of necessary medical care to
22 the maximum extent possible under Title XIX of the Federal
23 Social Security Act.

24 (b) The Illinois Department and the Governor shall
25 provide a plan for coverage of the persons eligible under
26 paragraph 5(a) by April 1, 1990. Such plan shall provide

1 ambulatory prenatal care to pregnant women during a
2 presumptive eligibility period and establish an income
3 eligibility standard that is equal to 133% of the nonfarm
4 income official poverty line, as defined by the federal
5 Office of Management and Budget and revised annually in
6 accordance with Section 673(2) of the Omnibus Budget
7 Reconciliation Act of 1981, applicable to families of the
8 same size, provided that costs incurred for medical care
9 are not taken into account in determining such income
10 eligibility.

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

23 6. Persons under the age of 18 who fail to qualify as
24 dependent under Article IV and who have insufficient income
25 and resources to meet the costs of necessary medical care
26 to the maximum extent permitted under Title XIX of the

1 Federal Social Security Act.

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

8 ~~(a) the person requires a level of care provided by~~
9 ~~a hospital, skilled nursing facility, or intermediate~~
10 ~~care facility, as determined by a physician licensed to~~
11 ~~practice medicine in all its branches;~~

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

15 ~~(c) the estimated amount which would be expended~~
16 ~~for care outside the institution is not greater than~~
17 ~~the estimated amount which would be expended in an~~
18 ~~institution.~~

19 8. Persons who become ineligible for basic maintenance
20 assistance under Article IV of this Code in programs
21 administered by the Illinois Department due to employment
22 earnings and persons in assistance units comprised of
23 adults and children who become ineligible for basic
24 maintenance assistance under Article VI of this Code due to
25 employment earnings. The plan for coverage for this class
26 of persons shall:

1 (a) extend the medical assistance coverage for up
2 to 12 months following termination of basic
3 maintenance assistance; and

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

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

10 (ii) such coverage shall include all services
11 covered while the person was eligible for basic
12 maintenance assistance;

13 (iii) no premium shall be charged for such
14 coverage; and

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

22 9. Persons with acquired immunodeficiency syndrome
23 (AIDS) or with AIDS-related conditions with respect to whom
24 there has been a determination that but for home or
25 community-based services such individuals would require
26 the level of care provided in an inpatient hospital,

1 skilled nursing facility or intermediate care facility the
2 cost of which is reimbursed under this Article. Assistance
3 shall be provided to such persons to the maximum extent
4 permitted under Title XIX of the Federal Social Security
5 Act.

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

11 11. Persons with disabilities who are employed and
12 eligible for Medicaid, pursuant to Section
13 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,
14 subject to federal approval, persons with a medically
15 improved disability who are employed and eligible for
16 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
17 the Social Security Act, as provided by the Illinois
18 Department by rule. In establishing eligibility standards
19 under this paragraph 11, the Department shall, subject to
20 federal approval:

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

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

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

4 (d) continue to apply subparagraphs (b) and (c) in
5 determining the eligibility of the person under this
6 Article even if the person loses eligibility under this
7 paragraph 11.

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

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

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

26 "Medical assistance" under this paragraph 12 shall be

1 identical to the benefits provided under the State's
2 approved plan under Title XIX of the Social Security Act.
3 The Department must request federal approval of the
4 coverage under this paragraph 12 within 30 days after the
5 effective date of this amendatory Act of the 92nd General
6 Assembly.

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

25 13. Subject to appropriation and to federal approval,
26 persons living with HIV/AIDS who are not otherwise eligible

1 under this Article and who qualify for services covered
2 under Section 5-5.04 as provided by the Illinois Department
3 by rule.

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

26 15. Family Care Eligibility.

1 (a) On and after July 1, 2012 ~~Through December 31,~~
2 ~~2013,~~ a caretaker relative who is 19 years of age or
3 older when countable income is at or below 133% ~~185%~~ of
4 the Federal Poverty Level Guidelines, as published
5 annually in the Federal Register, for the appropriate
6 family size. ~~Beginning January 1, 2014, a caretaker~~
7 ~~relative who is 19 years of age or older when countable~~
8 ~~income is at or below 133% of the Federal Poverty Level~~
9 ~~Guidelines, as published annually in the Federal~~
10 ~~Register, for the appropriate family size.~~ A person may
11 not spend down to become eligible under this paragraph
12 15.

13 (b) Eligibility shall be reviewed annually.

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

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

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

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

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

4 (h) (Blank). ~~Partial premium payments shall not be~~
5 ~~refunded.~~

6 (i) Following termination of an individual's
7 coverage under this paragraph 15, the individual must
8 be determined eligible before the person can be
9 re-enrolled. ~~following action is required before the~~
10 ~~individual can be re enrolled:~~

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

13 ~~(2) There must be full payment of premiums due~~
14 ~~under this Code, the Children's Health Insurance~~
15 ~~Program Act, the Covering ALL KIDS Health~~
16 ~~Insurance Act, or any other healthcare program~~
17 ~~administered by the Department for periods in~~
18 ~~which a premium was owed and not paid for the~~
19 ~~individual.~~

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

23 ~~The Department is authorized to implement the~~
24 ~~provisions of this amendatory Act of the 95th General~~
25 ~~Assembly by adopting the medical assistance rules in effect~~
26 ~~as of October 1, 2007, at 89 Ill. Admin. Code 125, and at~~

1 ~~89 Ill. Admin. Code 120.32 along with only those changes~~
2 ~~necessary to conform to federal Medicaid requirements,~~
3 ~~federal laws, and federal regulations, including but not~~
4 ~~limited to Section 1931 of the Social Security Act (42~~
5 ~~U.S.C. Sec. 1396u 1), as interpreted by the U.S. Department~~
6 ~~of Health and Human Services, and the countable income~~
7 ~~eligibility standard authorized by this paragraph 15. The~~
8 ~~Department may not otherwise adopt any rule to implement~~
9 ~~this increase except as authorized by law, to meet the~~
10 ~~eligibility standards authorized by the federal government~~
11 ~~in the Medicaid State Plan or the Title XXI Plan, or to~~
12 ~~meet an order from the federal government or any court.~~

13 16. Subject to appropriation, uninsured persons who
14 are not otherwise eligible under this Section who have been
15 certified and referred by the Department of Public Health
16 as having been screened and found to need diagnostic
17 evaluation or treatment, or both diagnostic evaluation and
18 treatment, for prostate or testicular cancer. For the
19 purposes of this paragraph 16, uninsured persons are those
20 who do not have creditable coverage, as defined under the
21 Health Insurance Portability and Accountability Act, or
22 have otherwise exhausted any insurance benefits they may
23 have had, for prostate or testicular cancer diagnostic
24 evaluation or treatment, or both diagnostic evaluation and
25 treatment. To be eligible, a person must furnish a Social
26 Security number. A person's assets are exempt from

1 consideration in determining eligibility under this
2 paragraph 16. Such persons shall be eligible for medical
3 assistance under this paragraph 16 for so long as they need
4 treatment for the cancer. A person shall be considered to
5 need treatment if, in the opinion of the person's treating
6 physician, the person requires therapy directed toward
7 cure or palliation of prostate or testicular cancer,
8 including recurrent metastatic cancer that is a known or
9 presumed complication of prostate or testicular cancer and
10 complications resulting from the treatment modalities
11 themselves. Persons who require only routine monitoring
12 services are not considered to need treatment. "Medical
13 assistance" under this paragraph 16 shall be identical to
14 the benefits provided under the State's approved plan under
15 Title XIX of the Social Security Act. Notwithstanding any
16 other provision of law, the Department (i) does not have a
17 claim against the estate of a deceased recipient of
18 services under this paragraph 16 and (ii) does not have a
19 lien against any homestead property or other legal or
20 equitable real property interest owned by a recipient of
21 services under this paragraph 16.

22 In implementing the provisions of Public Act 96-20, the
23 Department is authorized to adopt only those rules necessary,
24 including emergency rules. Nothing in Public Act 96-20 permits
25 the Department to adopt rules or issue a decision that expands
26 eligibility for the FamilyCare Program to a person whose income

1 exceeds 185% of the Federal Poverty Level as determined from
2 time to time by the U.S. Department of Health and Human
3 Services, unless the Department is provided with express
4 statutory authority.

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

8 The eligibility of any such person for medical assistance
9 under this Article is not affected by the payment of any grant
10 under the Senior Citizens and Disabled Persons Property Tax
11 Relief ~~and Pharmaceutical Assistance~~ Act or any distributions
12 or items of income described under subparagraph (X) of
13 paragraph (2) of subsection (a) of Section 203 of the Illinois
14 Income Tax Act. The Department shall by rule establish the
15 amounts of assets to be disregarded in determining eligibility
16 for medical assistance, which shall at a minimum equal the
17 amounts to be disregarded under the Federal Supplemental
18 Security Income Program. The amount of assets of a single
19 person to be disregarded shall not be less than \$2,000, and the
20 amount of assets of a married couple to be disregarded shall
21 not be less than \$3,000.

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

26 The eligibility of any person for medical assistance under

1 this Article shall not be affected by the receipt by the person
2 of donations or benefits from fundraisers held for the person
3 in cases of serious illness, as long as neither the person nor
4 members of the person's family have actual control over the
5 donations or benefits or the disbursement of the donations or
6 benefits.

7 (Source: P.A. 96-20, eff. 6-30-09; 96-181, eff. 8-10-09;
8 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff.
9 7-2-10; 96-1123, eff. 1-1-11; 96-1270, eff. 7-26-10; 97-48,
10 eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11;
11 revised 10-4-11.)

12 (305 ILCS 5/5-2b new)

13 Sec. 5-2b. Medically fragile and technology dependent
14 children eligibility and program. Notwithstanding any other
15 provision of law, on and after September 1, 2012, subject to
16 federal approval, medical assistance under this Article shall
17 be available to children who qualify as persons with a
18 disability, as defined under the federal Supplemental Security
19 Income program and who are medically fragile and technology
20 dependent. The program shall allow eligible children to receive
21 the medical assistance provided under this Article in the
22 community, shall be limited to families with income up to 500%
23 of the federal poverty level, and must maximize, to the fullest
24 extent permissible under federal law, federal reimbursement
25 and family cost-sharing, including co-pays, premiums, or any

1 other family contributions, except that the Department shall be
2 permitted to incentivize the utilization of selected services
3 through the use of cost-sharing adjustments. The Department
4 shall establish the policies, procedures, standards, services,
5 and criteria for this program by rule.

6 (305 ILCS 5/5-2.1d new)

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

18 (305 ILCS 5/5-4) (from Ch. 23, par. 5-4)

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

20 (a) The amount and nature of medical assistance shall be
21 determined ~~by the County Departments~~ in accordance with the
22 standards, rules, and regulations of the Department of
23 Healthcare and Family Services, with due regard to the
24 requirements and conditions in each case, including

1 contributions available from legally responsible relatives.
2 However, the amount and nature of such medical assistance shall
3 not be affected by the payment of any grant under the Senior
4 Citizens and Disabled Persons Property Tax Relief ~~and~~
5 ~~Pharmaceutical Assistance~~ Act or any distributions or items of
6 income described under subparagraph (X) of paragraph (2) of
7 subsection (a) of Section 203 of the Illinois Income Tax Act.
8 The amount and nature of medical assistance shall not be
9 affected by the receipt of donations or benefits from
10 fundraisers in cases of serious illness, as long as neither the
11 person nor members of the person's family have actual control
12 over the donations or benefits or the disbursement of the
13 donations or benefits.

14 In determining the income and resources ~~assets~~ available to
15 the institutionalized spouse and to the community spouse, the
16 Department of Healthcare and Family Services shall follow the
17 procedures established by federal law. If an institutionalized
18 spouse or community spouse refuses to comply with the
19 requirements of Title XIX of the federal Social Security Act
20 and the regulations duly promulgated thereunder by failing to
21 provide the total value of assets, including income and
22 resources, to the extent either the institutionalized spouse or
23 community spouse has an ownership interest in them pursuant to
24 42 U.S.C. 1396r-5, such refusal may result in the
25 institutionalized spouse being denied eligibility and
26 continuing to remain ineligible for the medical assistance

1 program based on failure to cooperate.

2 Subject to federal approval, the ~~The~~ community spouse
3 resource allowance shall be established and maintained at the
4 higher of \$109,560 or the minimum ~~maximum~~ level permitted
5 pursuant to Section 1924(f)(2) of the Social Security Act, as
6 now or hereafter amended, or an amount set after a fair
7 hearing, whichever is greater. The monthly maintenance
8 allowance for the community spouse shall be established and
9 maintained at the higher of \$2,739 per month or the minimum
10 ~~maximum~~ level permitted pursuant to Section 1924(d)(3)(C) of
11 the Social Security Act, as now or hereafter amended, or an
12 amount set after a fair hearing, whichever is greater. Subject
13 to the approval of the Secretary of the United States
14 Department of Health and Human Services, the provisions of this
15 Section shall be extended to persons who but for the provision
16 of home or community-based services under Section 4.02 of the
17 Illinois Act on the Aging, would require the level of care
18 provided in an institution, as is provided for in federal law.

19 (b) Spousal support for institutionalized spouses
20 receiving medical assistance.

21 (i) The Department may seek support for an
22 institutionalized spouse, who has assigned his or her right
23 of support from his or her spouse to the State, from the
24 resources and income available to the community spouse.

25 (ii) The Department may bring an action in the circuit
26 court to establish support orders or itself establish

1 administrative support orders by any means and procedures
2 authorized in this Code, as applicable, except that the
3 standard and regulations for determining ability to
4 support in Section 10-3 shall not limit the amount of
5 support that may be ordered.

6 (iii) Proceedings may be initiated to obtain support,
7 or for the recovery of aid granted during the period such
8 support was not provided, or both, for the obtainment of
9 support and the recovery of the aid provided. Proceedings
10 for the recovery of aid may be taken separately or they may
11 be consolidated with actions to obtain support. Such
12 proceedings may be brought in the name of the person or
13 persons requiring support or may be brought in the name of
14 the Department, as the case requires.

15 (iv) The orders for the payment of moneys for the
16 support of the person shall be just and equitable and may
17 direct payment thereof for such period or periods of time
18 as the circumstances require, including support for a
19 period before the date the order for support is entered. In
20 no event shall the orders reduce the community spouse
21 resource allowance below the level established in
22 subsection (a) of this Section or an amount set after a
23 fair hearing, whichever is greater, or reduce the monthly
24 maintenance allowance for the community spouse below the
25 level permitted pursuant to subsection (a) of this Section.
26 The Department of Human Services shall notify in writing

1 ~~each institutionalized spouse who is a recipient of medical~~
2 ~~assistance under this Article, and each such person's community~~
3 ~~spouse, of the changes in treatment of income and resources,~~
4 ~~including provisions for protecting income for a community~~
5 ~~spouse and permitting the transfer of resources to a community~~
6 ~~spouse, required by enactment of the federal Medicare~~
7 ~~Catastrophic Coverage Act of 1988 (Public Law 100-360). The~~
8 ~~notification shall be in language likely to be easily~~
9 ~~understood by those persons. The Department of Human Services~~
10 ~~also shall reassess the amount of medical assistance for which~~
11 ~~each such recipient is eligible as a result of the enactment of~~
12 ~~that federal Act, whether or not a recipient requests such a~~
13 ~~reassessment.~~

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

15 (305 ILCS 5/5-4.1) (from Ch. 23, par. 5-4.1)

16 Sec. 5-4.1. Co-payments. The Department may by rule provide
17 that recipients under any Article of this Code shall pay a fee
18 as a co-payment for services. Co-payments shall be maximized to
19 the extent permitted by federal law, except that the Department
20 shall impose a co-pay of \$2 on generic drugs. Provided,
21 however, that any such rule must provide that no co-payment
22 requirement can exist for renal dialysis, radiation therapy,
23 cancer chemotherapy, or insulin, and other products necessary
24 on a recurring basis, the absence of which would be life
25 threatening, or where co-payment expenditures for required

1 services and/or medications for chronic diseases that the
2 Illinois Department shall by rule designate shall cause an
3 extensive financial burden on the recipient, and provided no
4 co-payment shall exist for emergency room encounters which are
5 for medical emergencies. The Department shall seek approval of
6 a State plan amendment that allows pharmacies to refuse to
7 dispense drugs in circumstances where the recipient does not
8 pay the required co-payment. ~~In the event the State plan~~
9 ~~amendment is rejected, co payments may not exceed \$3 for brand~~
10 ~~name drugs, \$1 for other pharmacy services other than for~~
11 ~~generic drugs, and \$2 for physician services, dental services,~~
12 ~~optical services and supplies, chiropractic services, podiatry~~
13 ~~services, and encounter rate clinic services. There shall be no~~
14 ~~co-payment for generic drugs.~~ Co-payments may not exceed \$10
15 for emergency room use for a non-emergency situation as defined
16 by the Department by rule and subject to federal approval.

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

18 (305 ILCS 5/5-4.2) (from Ch. 23, par. 5-4.2)

19 Sec. 5-4.2. Ambulance services payments.

20 (a) For ambulance services provided to a recipient of aid
21 under this Article on or after January 1, 1993, the Illinois
22 Department shall reimburse ambulance service providers at
23 rates calculated in accordance with this Section. It is the
24 intent of the General Assembly to provide adequate
25 reimbursement for ambulance services so as to ensure adequate

1 access to services for recipients of aid under this Article and
2 to provide appropriate incentives to ambulance service
3 providers to provide services in an efficient and
4 cost-effective manner. Thus, it is the intent of the General
5 Assembly that the Illinois Department implement a
6 reimbursement system for ambulance services that, to the extent
7 practicable and subject to the availability of funds
8 appropriated by the General Assembly for this purpose, is
9 consistent with the payment principles of Medicare. To ensure
10 uniformity between the payment principles of Medicare and
11 Medicaid, the Illinois Department shall follow, to the extent
12 necessary and practicable and subject to the availability of
13 funds appropriated by the General Assembly for this purpose,
14 the statutes, laws, regulations, policies, procedures,
15 principles, definitions, guidelines, and manuals used to
16 determine the amounts paid to ambulance service providers under
17 Title XVIII of the Social Security Act (Medicare).

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

25 (c) For purposes of this Section, "ambulance services"
26 includes medical transportation services provided by means of

1 an ambulance, medi-car, service car, or taxi.

2 (c-1) For purposes of this Section, "ground ambulance
3 service" means medical transportation services that are
4 described as ground ambulance services by the Centers for
5 Medicare and Medicaid Services and provided in a vehicle that
6 is licensed as an ambulance by the Illinois Department of
7 Public Health pursuant to the Emergency Medical Services (EMS)
8 Systems Act.

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

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

20 (e) Beginning with services rendered on or after July 1,
21 2008, all providers of non-emergency medi-car and service car
22 transportation must certify that the driver and employee
23 attendant, as applicable, have completed a safety program
24 approved by the Department to protect both the patient and the
25 driver, prior to transporting a patient. The provider must
26 maintain this certification in its records. The provider shall

1 produce such documentation upon demand by the Department or its
2 representative. Failure to produce documentation of such
3 training shall result in recovery of any payments made by the
4 Department for services rendered by a non-certified driver or
5 employee attendant. Medi-car and service car providers must
6 maintain legible documentation in their records of the driver
7 and, as applicable, employee attendant that actually
8 transported the patient. Providers must recertify all drivers
9 and employee attendants every 3 years.

10 Notwithstanding the requirements above, any public
11 transportation provider of medi-car and service car
12 transportation that receives federal funding under 49 U.S.C.
13 5307 and 5311 need not certify its drivers and employee
14 attendants under this Section, since safety training is already
15 federally mandated.

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

1 ambulance service or (ii) grants a request for approval of
2 non-emergency transportation by means of ground ambulance
3 service at a level of service that entitles the ground
4 ambulance service provider to a lower level of compensation
5 from the Department than the ground ambulance service provider
6 would have received as compensation for the level of service
7 requested. The rule shall be filed by December 15, 2012
8 ~~established within 12 months after the effective date of this~~
9 ~~amendatory Act of the 97th General Assembly~~ and shall provide
10 that, for any decision rendered by the Department or its agent
11 on or after the date the rule takes effect, the ground
12 ambulance service provider shall have 60 days from the date the
13 decision is received to file an appeal. The rule established by
14 the Department shall be, insofar as is practical, consistent
15 with the Illinois Administrative Procedure Act. The Director's
16 decision on an appeal under this Section shall be a final
17 administrative decision subject to review under the
18 Administrative Review Law.

19 (g) Whenever a patient covered by a medical assistance
20 program under this Code or by another medical program
21 administered by the Department is being discharged from a
22 facility, a physician discharge order as described in this
23 Section shall be required for each patient whose discharge
24 requires medically supervised ground ambulance services.
25 Facilities shall develop procedures for a physician with
26 medical staff privileges to provide a written and signed

1 physician discharge order. The physician discharge order shall
2 specify the level of ground ambulance services needed and
3 complete a medical certification establishing the criteria for
4 approval of non-emergency ambulance transportation, as
5 published by the Department of Healthcare and Family Services,
6 that is met by the patient. This order and the medical
7 certification shall be completed prior to ordering an ambulance
8 service and prior to patient discharge.

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

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

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

22 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

23 Sec. 5-5. Medical services. The Illinois Department, by
24 rule, shall determine the quantity and quality of and the rate
25 of reimbursement for the medical assistance for which payment

1 will be authorized, and the medical services to be provided,
2 which may include all or part of the following: (1) inpatient
3 hospital services; (2) outpatient hospital services; (3) other
4 laboratory and X-ray services; (4) skilled nursing home
5 services; (5) physicians' services whether furnished in the
6 office, the patient's home, a hospital, a skilled nursing home,
7 or elsewhere; (6) medical care, or any other type of remedial
8 care furnished by licensed practitioners; (7) home health care
9 services; (8) private duty nursing service; (9) clinic
10 services; (10) dental services, including prevention and
11 treatment of periodontal disease and dental caries disease for
12 pregnant women, provided by an individual licensed to practice
13 dentistry or dental surgery; for purposes of this item (10),
14 "dental services" means diagnostic, preventive, or corrective
15 procedures provided by or under the supervision of a dentist in
16 the practice of his or her profession; (11) physical therapy
17 and related services; (12) prescribed drugs, dentures, and
18 prosthetic devices; and eyeglasses prescribed by a physician
19 skilled in the diseases of the eye, or by an optometrist,
20 whichever the person may select; (13) other diagnostic,
21 screening, preventive, and rehabilitative services, for
22 children and adults; (14) transportation and such other
23 expenses as may be necessary; (15) medical treatment of sexual
24 assault survivors, as defined in Section 1a of the Sexual
25 Assault Survivors Emergency Treatment Act, for injuries
26 sustained as a result of the sexual assault, including

1 examinations and laboratory tests to discover evidence which
2 may be used in criminal proceedings arising from the sexual
3 assault; (16) the diagnosis and treatment of sickle cell
4 anemia; and (17) any other medical care, and any other type of
5 remedial care recognized under the laws of this State, but not
6 including abortions, or induced miscarriages or premature
7 births, unless, in the opinion of a physician, such procedures
8 are necessary for the preservation of the life of the woman
9 seeking such treatment, or except an induced premature birth
10 intended to produce a live viable child and such procedure is
11 necessary for the health of the mother or her unborn child. The
12 Illinois Department, by rule, shall prohibit any physician from
13 providing medical assistance to anyone eligible therefor under
14 this Code where such physician has been found guilty of
15 performing an abortion procedure in a wilful and wanton manner
16 upon a woman who was not pregnant at the time such abortion
17 procedure was performed. The term "any other type of remedial
18 care" shall include nursing care and nursing home service for
19 persons who rely on treatment by spiritual means alone through
20 prayer for healing.

21 Notwithstanding any other provision of this Section, a
22 comprehensive tobacco use cessation program that includes
23 purchasing prescription drugs or prescription medical devices
24 approved by the Food and Drug Administration shall be covered
25 under the medical assistance program under this Article for
26 persons who are otherwise eligible for assistance under this

1 Article.

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

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

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

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

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

1 health clinic or Federally Qualified Health Center or other
2 enrolled provider, as determined by the Department, through
3 which dental services covered under this Section are performed.
4 The Department shall establish a process for payment of claims
5 for reimbursement for covered dental services rendered under
6 this provision.

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

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

17 The Illinois Department shall authorize the provision of,
18 and shall authorize payment for, screening by low-dose
19 mammography for the presence of occult breast cancer for women
20 35 years of age or older who are eligible for medical
21 assistance under this Article, as follows:

22 (A) A baseline mammogram for women 35 to 39 years of
23 age.

24 (B) An annual mammogram for women 40 years of age or
25 older.

26 (C) A mammogram at the age and intervals considered

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

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

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

20 On and after January 1, 2012, providers participating in a
21 quality improvement program approved by the Department shall be
22 reimbursed for screening and diagnostic mammography at the same
23 rate as the Medicare program's rates, including the increased
24 reimbursement for digital mammography.

25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards.

3 Subject to federal approval, the Department shall
4 establish a rate methodology for mammography at federally
5 qualified health centers and other encounter-rate clinics.
6 These clinics or centers may also collaborate with other
7 hospital-based mammography facilities.

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

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

18 The Department shall devise a means of case-managing or
19 patient navigation for beneficiaries diagnosed with breast
20 cancer. This program shall initially operate as a pilot program
21 in areas of the State with the highest incidence of mortality
22 related to breast cancer. At least one pilot program site shall
23 be in the metropolitan Chicago area and at least one site shall
24 be outside the metropolitan Chicago area. An evaluation of the
25 pilot program shall be carried out measuring health outcomes
26 and cost of care for those served by the pilot program compared

1 to similarly situated patients who are not served by the pilot
2 program.

3 Any medical or health care provider shall immediately
4 recommend, to any pregnant woman who is being provided prenatal
5 services and is suspected of drug abuse or is addicted as
6 defined in the Alcoholism and Other Drug Abuse and Dependency
7 Act, referral to a local substance abuse treatment provider
8 licensed by the Department of Human Services or to a licensed
9 hospital which provides substance abuse treatment services.
10 The Department of Healthcare and Family Services shall assure
11 coverage for the cost of treatment of the drug abuse or
12 addiction for pregnant recipients in accordance with the
13 Illinois Medicaid Program in conjunction with the Department of
14 Human Services.

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

23 The Illinois Department, in cooperation with the
24 Departments of Human Services (as successor to the Department
25 of Alcoholism and Substance Abuse) and Public Health, through a
26 public awareness campaign, may provide information concerning

1 treatment for alcoholism and drug abuse and addiction, prenatal
2 health care, and other pertinent programs directed at reducing
3 the number of drug-affected infants born to recipients of
4 medical assistance.

5 Neither the Department of Healthcare and Family Services
6 nor the Department of Human Services shall sanction the
7 recipient solely on the basis of her substance abuse.

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

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

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

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

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

25 (2) The Department may elect to consider and negotiate
26 financial incentives to encourage the development of

1 Partnerships and the efficient delivery of medical care.

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

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

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

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

1 The Illinois Department shall require health care
2 providers to maintain records that document the medical care
3 and services provided to recipients of Medical Assistance under
4 this Article. Such records must be retained for a period of not
5 less than 6 years from the date of service or as provided by
6 applicable State law, whichever period is longer, except that
7 if an audit is initiated within the required retention period
8 then the records must be retained until the audit is completed
9 and every exception is resolved. The Illinois Department shall
10 require health care providers to make available, when
11 authorized by the patient, in writing, the medical records in a
12 timely fashion to other health care providers who are treating
13 or serving persons eligible for Medical Assistance under this
14 Article. All dispensers of medical services shall be required
15 to maintain and retain business and professional records
16 sufficient to fully and accurately document the nature, scope,
17 details and receipt of the health care provided to persons
18 eligible for medical assistance under this Code, in accordance
19 with regulations promulgated by the Illinois Department. The
20 rules and regulations shall require that proof of the receipt
21 of prescription drugs, dentures, prosthetic devices and
22 eyeglasses by eligible persons under this Section accompany
23 each claim for reimbursement submitted by the dispenser of such
24 medical services. No such claims for reimbursement shall be
25 approved for payment by the Illinois Department without such
26 proof of receipt, unless the Illinois Department shall have put

1 into effect and shall be operating a system of post-payment
2 audit and review which shall, on a sampling basis, be deemed
3 adequate by the Illinois Department to assure that such drugs,
4 dentures, prosthetic devices and eyeglasses for which payment
5 is being made are actually being received by eligible
6 recipients. Within 90 days after the effective date of this
7 amendatory Act of 1984, the Illinois Department shall establish
8 a current list of acquisition costs for all prosthetic devices
9 and any other items recognized as medical equipment and
10 supplies reimbursable under this Article and shall update such
11 list on a quarterly basis, except that the acquisition costs of
12 all prescription drugs shall be updated no less frequently than
13 every 30 days as required by Section 5-5.12.

14 The rules and regulations of the Illinois Department shall
15 require that a written statement including the required opinion
16 of a physician shall accompany any claim for reimbursement for
17 abortions, or induced miscarriages or premature births. This
18 statement shall indicate what procedures were used in providing
19 such medical services.

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

1 institutions or other legal entities providing any form of
2 health care services in this State under this Article.

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

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

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

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

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

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

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

1 exceptions:

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

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

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

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

21 In the case of long term care facilities, admission
22 documents shall be submitted within 30 days of an admission to
23 the facility through the Medical Electronic Data Interchange
24 (MEDI) or the Recipient Eligibility Verification (REV) System,
25 or shall be submitted directly to the Department of Human
26 Services using required admission forms. Confirmation numbers

1 assigned to an accepted transaction shall be retained by a
2 facility to verify timely submittal. Once an admission
3 transaction has been completed, all resubmitted claims
4 following prior rejection are subject to receipt no later than
5 180 days after the admission transaction has been completed.

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

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

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

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

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

1 take any action or acquire any products or services.

2 The Illinois Department shall establish policies,
3 procedures, standards and criteria by rule for the acquisition,
4 repair and replacement of orthotic and prosthetic devices and
5 durable medical equipment. Such rules shall provide, but not be
6 limited to, the following services: (1) immediate repair or
7 replacement of such devices by recipients ~~without medical~~
8 ~~authorization~~; and (2) rental, lease, purchase or
9 lease-purchase of durable medical equipment in a
10 cost-effective manner, taking into consideration the
11 recipient's medical prognosis, the extent of the recipient's
12 needs, and the requirements and costs for maintaining such
13 equipment. Subject to prior approval, such ~~Such~~ rules shall
14 enable a recipient to temporarily acquire and use alternative
15 or substitute devices or equipment pending repairs or
16 replacements of any device or equipment previously authorized
17 for such recipient by the Department.

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

1 federal approval, on and after July 1, 2012, an increase in the
2 determination of need (DON) scores from 29 to 37 for applicants
3 for institutional and home and community-based long term care;
4 if and only if federal approval is not granted, the Department
5 may, in conjunction with other affected agencies, implement
6 utilization controls or changes in benefit packages to
7 effectuate a similar savings amount for this population; and
8 (iv) no later than July 1, 2013, minimum level of care
9 eligibility criteria for institutional and home and
10 community-based long term care. In order to select the minimum
11 level of care eligibility criteria, the Governor shall
12 establish a workgroup that includes affected agency
13 representatives and stakeholders representing the
14 institutional and home and community-based long term care
15 interests. This Section shall not restrict the Department from
16 implementing lower level of care eligibility criteria for
17 community-based services in circumstances where federal
18 approval has been granted.

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

26 The Illinois Department shall report annually to the

1 General Assembly, no later than the second Friday in April of
2 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

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

9 (Source: P.A. 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926,
10 eff. 1-1-11; 96-1000, eff. 7-2-10; 97-48, eff. 6-28-11; 97-638,
11 eff. 1-1-12.)

12 (305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

13 Sec. 5-5.02. Hospital reimbursements.

14 (a) Reimbursement to Hospitals; July 1, 1992 through
15 September 30, 1992. Notwithstanding any other provisions of
16 this Code or the Illinois Department's Rules promulgated under
17 the Illinois Administrative Procedure Act, reimbursement to
18 hospitals for services provided during the period July 1, 1992
19 through September 30, 1992, shall be as follows:

20 (1) For inpatient hospital services rendered, or if
21 applicable, for inpatient hospital discharges occurring,
22 on or after July 1, 1992 and on or before September 30,
23 1992, the Illinois Department shall reimburse hospitals
24 for inpatient services under the reimbursement
25 methodologies in effect for each hospital, and at the

1 inpatient payment rate calculated for each hospital, as of
2 June 30, 1992. For purposes of this paragraph,
3 "reimbursement methodologies" means all reimbursement
4 methodologies that pertain to the provision of inpatient
5 hospital services, including, but not limited to, any
6 adjustments for disproportionate share, targeted access,
7 critical care access and uncompensated care, as defined by
8 the Illinois Department on June 30, 1992.

9 (2) For the purpose of calculating the inpatient
10 payment rate for each hospital eligible to receive
11 quarterly adjustment payments for targeted access and
12 critical care, as defined by the Illinois Department on
13 June 30, 1992, the adjustment payment for the period July
14 1, 1992 through September 30, 1992, shall be 25% of the
15 annual adjustment payments calculated for each eligible
16 hospital, as of June 30, 1992. The Illinois Department
17 shall determine by rule the adjustment payments for
18 targeted access and critical care beginning October 1,
19 1992.

20 (3) For the purpose of calculating the inpatient
21 payment rate for each hospital eligible to receive
22 quarterly adjustment payments for uncompensated care, as
23 defined by the Illinois Department on June 30, 1992, the
24 adjustment payment for the period August 1, 1992 through
25 September 30, 1992, shall be one-sixth of the total
26 uncompensated care adjustment payments calculated for each

1 eligible hospital for the uncompensated care rate year, as
2 defined by the Illinois Department, ending on July 31,
3 1992. The Illinois Department shall determine by rule the
4 adjustment payments for uncompensated care beginning
5 October 1, 1992.

6 (b) Inpatient payments. For inpatient services provided on
7 or after October 1, 1993, in addition to rates paid for
8 hospital inpatient services pursuant to the Illinois Health
9 Finance Reform Act, as now or hereafter amended, or the
10 Illinois Department's prospective reimbursement methodology,
11 or any other methodology used by the Illinois Department for
12 inpatient services, the Illinois Department shall make
13 adjustment payments, in an amount calculated pursuant to the
14 methodology described in paragraph (c) of this Section, to
15 hospitals that the Illinois Department determines satisfy any
16 one of the following requirements:

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

20 (2) Illinois hospitals that have a Medicaid inpatient
21 utilization rate which is at least one-half a standard
22 deviation above the mean Medicaid inpatient utilization
23 rate for all hospitals in Illinois receiving Medicaid
24 payments from the Illinois Department; or

25 (3) Illinois hospitals that on July 1, 1991 had a
26 Medicaid inpatient utilization rate, as defined in

1 paragraph (h) of this Section, that was at least the mean
2 Medicaid inpatient utilization rate for all hospitals in
3 Illinois receiving Medicaid payments from the Illinois
4 Department and which were located in a planning area with
5 one-third or fewer excess beds as determined by the Health
6 Facilities and Services Review Board, and that, as of June
7 30, 1992, were located in a federally designated Health
8 Manpower Shortage Area; or

9 (4) Illinois hospitals that:

10 (A) have a Medicaid inpatient utilization rate
11 that is at least equal to the mean Medicaid inpatient
12 utilization rate for all hospitals in Illinois
13 receiving Medicaid payments from the Department; and

14 (B) also have a Medicaid obstetrical inpatient
15 utilization rate that is at least one standard
16 deviation above the mean Medicaid obstetrical
17 inpatient utilization rate for all hospitals in
18 Illinois receiving Medicaid payments from the
19 Department for obstetrical services; or

20 (5) Any children's hospital, which means a hospital
21 devoted exclusively to caring for children. A hospital
22 which includes a facility devoted exclusively to caring for
23 children shall be considered a children's hospital to the
24 degree that the hospital's Medicaid care is provided to
25 children if either (i) the facility devoted exclusively to
26 caring for children is separately licensed as a hospital by

1 a municipality prior to September 30, 1998 or (ii) the
2 hospital has been designated by the State as a Level III
3 perinatal care facility, has a Medicaid Inpatient
4 Utilization rate greater than 55% for the rate year 2003
5 disproportionate share determination, and has more than
6 10,000 qualified children days as defined by the Department
7 in rulemaking.

8 (c) Inpatient adjustment payments. The adjustment payments
9 required by paragraph (b) shall be calculated based upon the
10 hospital's Medicaid inpatient utilization rate as follows:

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

14 (2) hospitals with a Medicaid inpatient utilization
15 rate that is equal to or greater than the mean Medicaid
16 inpatient utilization rate but less than one standard
17 deviation above the mean Medicaid inpatient utilization
18 rate shall receive a per day adjustment payment equal to
19 the sum of \$25 plus \$1 for each one percent that the
20 hospital's Medicaid inpatient utilization rate exceeds the
21 mean Medicaid inpatient utilization rate;

22 (3) hospitals with a Medicaid inpatient utilization
23 rate that is equal to or greater than one standard
24 deviation above the mean Medicaid inpatient utilization
25 rate but less than 1.5 standard deviations above the mean
26 Medicaid inpatient utilization rate shall receive a per day

1 adjustment payment equal to the sum of \$40 plus \$7 for each
2 one percent that the hospital's Medicaid inpatient
3 utilization rate exceeds one standard deviation above the
4 mean Medicaid inpatient utilization rate; and

5 (4) hospitals with a Medicaid inpatient utilization
6 rate that is equal to or greater than 1.5 standard
7 deviations above the mean Medicaid inpatient utilization
8 rate shall receive a per day adjustment payment equal to
9 the sum of \$90 plus \$2 for each one percent that the
10 hospital's Medicaid inpatient utilization rate exceeds 1.5
11 standard deviations above the mean Medicaid inpatient
12 utilization rate.

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

23 (e) The inpatient adjustment payments described in
24 paragraphs (c) and (d) shall be increased on October 1, 1993
25 and annually thereafter by a percentage equal to the lesser of
26 (i) the increase in the DRI hospital cost index for the most

1 recent 12 month period for which data are available, or (ii)
2 the percentage increase in the statewide average hospital
3 payment rate over the previous year's statewide average
4 hospital payment rate. The sum of the inpatient adjustment
5 payments under paragraphs (c) and (d) to a hospital, other than
6 a county hospital (as defined in subsection (c) of Section 15-1
7 of this Code) or a hospital organized under the University of
8 Illinois Hospital Act, however, shall not exceed \$275 per day;
9 that limit shall be increased on October 1, 1993 and annually
10 thereafter by a percentage equal to the lesser of (i) the
11 increase in the DRI hospital cost index for the most recent
12 12-month period for which data are available or (ii) the
13 percentage increase in the statewide average hospital payment
14 rate over the previous year's statewide average hospital
15 payment rate.

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

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

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

26 (1) "Medicaid inpatient utilization rate" means a

1 fraction, the numerator of which is the number of a
2 hospital's inpatient days provided in a given 12-month
3 period to patients who, for such days, were eligible for
4 Medicaid under Title XIX of the federal Social Security
5 Act, and the denominator of which is the total number of
6 the hospital's inpatient days in that same period.

7 (2) "Mean Medicaid inpatient utilization rate" means
8 the total number of Medicaid inpatient days provided by all
9 Illinois Medicaid-participating hospitals divided by the
10 total number of inpatient days provided by those same
11 hospitals.

12 (3) "Medicaid obstetrical inpatient utilization rate"
13 means the ratio of Medicaid obstetrical inpatient days to
14 total Medicaid inpatient days for all Illinois hospitals
15 receiving Medicaid payments from the Illinois Department.

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

20 (j) University of Illinois Hospital inpatient adjustment
21 payments. For hospitals organized under the University of
22 Illinois Hospital Act, there shall be an adjustment payment as
23 determined by rules adopted by the Illinois Department.

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

1 (1) 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. 96-31, eff. 6-30-09.)

7 (305 ILCS 5/5-5.05)

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

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

12 (b) For purposes of this Section, "hospital" means the
13 following:

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

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

16 (3) BroMenn Healthcare, Bloomington, Illinois.

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

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

19 (6) Lawrence County Memorial Hospital, Lawrenceville,
20 Illinois.

21 (7) Advocate Lutheran General Hospital, Park Ridge,
22 Illinois.

23 (8) Mercy Hospital and Medical Center, Chicago,
24 Illinois.

25 (9) Methodist Medical Center of Illinois, Peoria,

1 Illinois.

2 (10) Provena United Samaritans Medical Center,
3 Danville, Illinois.

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

5 (12) Sarah Bush Lincoln Health Center, Mattoon,
6 Illinois.

7 (13) Provena Covenant Medical Center, Urbana,
8 Illinois.

9 (14) Rush-Presbyterian-St. Luke's Medical Center,
10 Chicago, Illinois.

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

12 (16) Gateway Regional Medical Center, Granite City,
13 Illinois.

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

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

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

17 (20) Memorial Hospital, Belleville, Illinois.

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

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

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

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

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

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

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

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

26 (29) Loretto Hospital, Chicago, Illinois.

1 (30) Kenneth Hall Regional Hospital, East St. Louis,
2 Illinois.

3 (31) Hinsdale Hospital, Hinsdale, Illinois.

4 (32) Pekin Hospital, Pekin, Illinois.

5 (33) University of Chicago Medical Center, Chicago,
6 Illinois.

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

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

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

10 (37) A hospital with a distinct part unit for
11 psychiatric services that begins operating on or after July
12 1, 2008.

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

17 (c) No rules shall be promulgated to implement this
18 Section. For purposes of this Section, "rules" is given the
19 meaning contained in Section 1-70 of the Illinois
20 Administrative Procedure Act.

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

26 (e) On and after July 1, 2012, the Department shall reduce

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

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

6 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

7 Sec. 5-5.2. Payment.

8 (a) All nursing facilities that are grouped pursuant to
9 Section 5-5.1 of this Act shall receive the same rate of
10 payment for similar services.

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

14 (c) Notwithstanding any other provisions of this Code,
15 ~~beginning July 1, 2012~~ the methodologies for reimbursement of
16 nursing ~~facility~~ services as provided under this Article shall
17 no longer be applicable for bills payable for nursing services
18 rendered on or after a new reimbursement system based on the
19 Resource Utilization Groups (RUGs) has been fully
20 operationalized, which shall take effect for services provided
21 on or after January 1, 2014. ~~State fiscal years 2012 and~~
22 ~~thereafter. The Department of Healthcare and Family Services~~
23 ~~shall, effective July 1, 2012, implement an evidence-based~~
24 ~~payment methodology for the reimbursement of nursing facility~~
25 ~~services. The methodology shall continue to take into~~

1 ~~consideration the needs of individual residents, as assessed~~
2 ~~and reported by the most current version of the nursing~~
3 ~~facility Resident Assessment Instrument, adopted and in use by~~
4 ~~the federal government.~~

5 (d) A new nursing services reimbursement methodology
6 utilizing RUGs IV 48 grouper model shall be established and may
7 include an Illinois-specific default group, as needed. The new
8 RUGs-based nursing services reimbursement methodology shall be
9 resident-driven, facility-specific, and cost-based. Costs
10 shall be annually rebased and case mix index quarterly updated.
11 The methodology shall include regional wage adjustors based on
12 the Health Service Areas (HSA) groupings in effect on April 30,
13 2012. The Department shall assign a case mix index to each
14 resident class based on the Centers for Medicare and Medicaid
15 Services staff time measurement study utilizing an index
16 maximization approach.

17 (e) Notwithstanding any other provision of this Code, the
18 Department shall by rule develop a reimbursement methodology
19 reflective of the intensity of care and services requirements
20 of low need residents in the lowest RUG IV groupers and
21 corresponding regulations.

22 (f) Notwithstanding any other provision of this Code, on
23 and after July 1, 2012, reimbursement rates associated with the
24 nursing or support components of the current nursing facility
25 rate methodology shall not increase beyond the level effective
26 May 1, 2011 until a new reimbursement system based on the RUGs

1 IV 48 grouper model has been fully operationalized.

2 (g) Notwithstanding any other provision of this Code, on
3 and after July 1, 2012, for facilities not designated by the
4 Department of Healthcare and Family Services as "Institutions
5 for Mental Disease", rates effective May 1, 2011 shall be
6 adjusted as follows:

7 (1) Individual nursing rates for residents classified
8 in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter
9 ending March 31, 2012 shall be reduced by 10%;

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

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

14 (h) Notwithstanding any other provision of this Code, on
15 and after July 1, 2012, nursing facilities designated by the
16 Department of Healthcare and Family Services as "Institutions
17 for Mental Disease" and "Institutions for Mental Disease" that
18 are facilities licensed under the Specialized Mental Health
19 Rehabilitation Act shall have the nursing,
20 socio-developmental, capital, and support components of their
21 reimbursement rate effective May 1, 2011 reduced in total by
22 2.7%.

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

24 (305 ILCS 5/5-5.3) (from Ch. 23, par. 5-5.3)

25 Sec. 5-5.3. Conditions of Payment - Prospective Rates -

1 Accounting Principles. This amendatory Act establishes certain
2 conditions for the Department of Healthcare and Family Services
3 in instituting rates for the care of recipients of medical
4 assistance in nursing facilities and ICF/DDs. Such conditions
5 shall assure a method under which the payment for nursing
6 facility and ICF/DD services provided to recipients under the
7 Medical Assistance Program shall be on a reasonable cost
8 related basis, which is prospectively determined at least
9 annually by the Department of Public Aid (now Healthcare and
10 Family Services). The annually established payment rate shall
11 take effect on July 1 in 1984 and subsequent years. There shall
12 be no rate increase during calendar year 1983 and the first six
13 months of calendar year 1984.

14 The determination of the payment shall be made on the basis
15 of generally accepted accounting principles that shall take
16 into account the actual costs to the facility of providing
17 nursing facility and ICF/DD services to recipients under the
18 medical assistance program.

19 The resultant total rate for a specified type of service
20 shall be an amount which shall have been determined to be
21 adequate to reimburse allowable costs of a facility that is
22 economically and efficiently operated. The Department shall
23 establish an effective date for each facility or group of
24 facilities after which rates shall be paid on a reasonable cost
25 related basis which shall be no sooner than the effective date
26 of this amendatory Act of 1977.

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. 95-331, eff. 8-21-07; 96-1530, eff. 2-16-11.)

7 (305 ILCS 5/5-5.4) (from Ch. 23, par. 5-5.4)

8 Sec. 5-5.4. Standards of Payment - Department of Healthcare
9 and Family Services. The Department of Healthcare and Family
10 Services shall develop standards of payment of nursing facility
11 and ICF/DD services in facilities providing such services under
12 this Article which:

13 (1) Provide for the determination of a facility's payment
14 for nursing facility or ICF/DD services on a prospective basis.
15 The amount of the payment rate for all nursing facilities
16 certified by the Department of Public Health under the ID/DD
17 Community Care Act or the Nursing Home Care Act as Intermediate
18 Care for the Developmentally Disabled facilities, Long Term
19 Care for Under Age 22 facilities, Skilled Nursing facilities,
20 or Intermediate Care facilities under the medical assistance
21 program shall be prospectively established annually on the
22 basis of historical, financial, and statistical data
23 reflecting actual costs from prior years, which shall be
24 applied to the current rate year and updated for inflation,
25 except that the capital cost element for newly constructed

1 facilities shall be based upon projected budgets. The annually
2 established payment rate shall take effect on July 1 in 1984
3 and subsequent years. No rate increase and no update for
4 inflation shall be provided on or after July 1, 1994 and before
5 January 1, 2014 ~~July 1, 2012~~, unless specifically provided for
6 in this Section. The changes made by Public Act 93-841
7 extending the duration of the prohibition against a rate
8 increase or update for inflation are effective retroactive to
9 July 1, 2004.

10 For facilities licensed by the Department of Public Health
11 under the Nursing Home Care Act as Intermediate Care for the
12 Developmentally Disabled facilities or Long Term Care for Under
13 Age 22 facilities, the rates taking effect on July 1, 1998
14 shall include an increase of 3%. For facilities licensed by the
15 Department of Public Health under the Nursing Home Care Act as
16 Skilled Nursing facilities or Intermediate Care facilities,
17 the rates taking effect on July 1, 1998 shall include an
18 increase of 3% plus \$1.10 per resident-day, as defined by the
19 Department. For facilities licensed by the Department of Public
20 Health under the Nursing Home Care Act as Intermediate Care
21 Facilities for the Developmentally Disabled or Long Term Care
22 for Under Age 22 facilities, the rates taking effect on January
23 1, 2006 shall include an increase of 3%. For facilities
24 licensed by the Department of Public Health under the Nursing
25 Home Care Act as Intermediate Care Facilities for the
26 Developmentally Disabled or Long Term Care for Under Age 22

1 facilities, the rates taking effect on January 1, 2009 shall
2 include an increase sufficient to provide a \$0.50 per hour wage
3 increase for non-executive staff.

4 For facilities licensed by the Department of Public Health
5 under the Nursing Home Care Act as Intermediate Care for the
6 Developmentally Disabled facilities or Long Term Care for Under
7 Age 22 facilities, the rates taking effect on July 1, 1999
8 shall include an increase of 1.6% plus \$3.00 per resident-day,
9 as defined by the Department. For facilities licensed by the
10 Department of Public Health under the Nursing Home Care Act as
11 Skilled Nursing facilities or Intermediate Care facilities,
12 the rates taking effect on July 1, 1999 shall include an
13 increase of 1.6% and, for services provided on or after October
14 1, 1999, shall be increased by \$4.00 per resident-day, as
15 defined by the Department.

16 For facilities licensed by the Department of Public Health
17 under the Nursing Home Care Act as Intermediate Care for the
18 Developmentally Disabled facilities or Long Term Care for Under
19 Age 22 facilities, the rates taking effect on July 1, 2000
20 shall include an increase of 2.5% per resident-day, as defined
21 by the Department. For facilities licensed by the Department of
22 Public Health under the Nursing Home Care Act as Skilled
23 Nursing facilities or Intermediate Care facilities, the rates
24 taking effect on July 1, 2000 shall include an increase of 2.5%
25 per resident-day, as defined by the Department.

26 For facilities licensed by the Department of Public Health

1 under the Nursing Home Care Act as skilled nursing facilities
2 or intermediate care facilities, a new payment methodology must
3 be implemented for the nursing component of the rate effective
4 July 1, 2003. The Department of Public Aid (now Healthcare and
5 Family Services) shall develop the new payment methodology
6 using the Minimum Data Set (MDS) as the instrument to collect
7 information concerning nursing home resident condition
8 necessary to compute the rate. The Department shall develop the
9 new payment methodology to meet the unique needs of Illinois
10 nursing home residents while remaining subject to the
11 appropriations provided by the General Assembly. A transition
12 period from the payment methodology in effect on June 30, 2003
13 to the payment methodology in effect on July 1, 2003 shall be
14 provided for a period not exceeding 3 years and 184 days after
15 implementation of the new payment methodology as follows:

16 (A) For a facility that would receive a lower nursing
17 component rate per patient day under the new system than
18 the facility received effective on the date immediately
19 preceding the date that the Department implements the new
20 payment methodology, the nursing component rate per
21 patient day for the facility shall be held at the level in
22 effect on the date immediately preceding the date that the
23 Department implements the new payment methodology until a
24 higher nursing component rate of reimbursement is achieved
25 by that facility.

26 (B) For a facility that would receive a higher nursing

1 component rate per patient day under the payment
2 methodology in effect on July 1, 2003 than the facility
3 received effective on the date immediately preceding the
4 date that the Department implements the new payment
5 methodology, the nursing component rate per patient day for
6 the facility shall be adjusted.

7 (C) Notwithstanding paragraphs (A) and (B), the
8 nursing component rate per patient day for the facility
9 shall be adjusted subject to appropriations provided by the
10 General Assembly.

11 For facilities licensed by the Department of Public Health
12 under the Nursing Home Care Act as Intermediate Care for the
13 Developmentally Disabled facilities or Long Term Care for Under
14 Age 22 facilities, the rates taking effect on March 1, 2001
15 shall include a statewide increase of 7.85%, as defined by the
16 Department.

17 Notwithstanding any other provision of this Section, for
18 facilities licensed by the Department of Public Health under
19 the Nursing Home Care Act as skilled nursing facilities or
20 intermediate care facilities, except facilities participating
21 in the Department's demonstration program pursuant to the
22 provisions of Title 77, Part 300, Subpart T of the Illinois
23 Administrative Code, the numerator of the ratio used by the
24 Department of Healthcare and Family Services to compute the
25 rate payable under this Section using the Minimum Data Set
26 (MDS) methodology shall incorporate the following annual

1 amounts as the additional funds appropriated to the Department
2 specifically to pay for rates based on the MDS nursing
3 component methodology in excess of the funding in effect on
4 December 31, 2006:

5 (i) For rates taking effect January 1, 2007,
6 \$60,000,000.

7 (ii) For rates taking effect January 1, 2008,
8 \$110,000,000.

9 (iii) For rates taking effect January 1, 2009,
10 \$194,000,000.

11 (iv) For rates taking effect April 1, 2011, or the
12 first day of the month that begins at least 45 days after
13 the effective date of this amendatory Act of the 96th
14 General Assembly, \$416,500,000 or an amount as may be
15 necessary to complete the transition to the MDS methodology
16 for the nursing component of the rate. Increased payments
17 under this item (iv) are not due and payable, however,
18 until (i) the methodologies described in this paragraph are
19 approved by the federal government in an appropriate State
20 Plan amendment and (ii) the assessment imposed by Section
21 5B-2 of this Code is determined to be a permissible tax
22 under Title XIX of the Social Security Act.

23 Notwithstanding any other provision of this Section, for
24 facilities licensed by the Department of Public Health under
25 the Nursing Home Care Act as skilled nursing facilities or
26 intermediate care facilities, the support component of the

1 rates taking effect on January 1, 2008 shall be computed using
2 the most recent cost reports on file with the Department of
3 Healthcare and Family Services no later than April 1, 2005,
4 updated for inflation to January 1, 2006.

5 For facilities licensed by the Department of Public Health
6 under the Nursing Home Care Act as Intermediate Care for the
7 Developmentally Disabled facilities or Long Term Care for Under
8 Age 22 facilities, the rates taking effect on April 1, 2002
9 shall include a statewide increase of 2.0%, as defined by the
10 Department. This increase terminates on July 1, 2002; beginning
11 July 1, 2002 these rates are reduced to the level of the rates
12 in effect on March 31, 2002, as defined by the Department.

13 For facilities licensed by the Department of Public Health
14 under the Nursing Home Care Act as skilled nursing facilities
15 or intermediate care facilities, the rates taking effect on
16 July 1, 2001 shall be computed using the most recent cost
17 reports on file with the Department of Public Aid no later than
18 April 1, 2000, updated for inflation to January 1, 2001. For
19 rates effective July 1, 2001 only, rates shall be the greater
20 of the rate computed for July 1, 2001 or the rate effective on
21 June 30, 2001.

22 Notwithstanding any other provision of this Section, for
23 facilities licensed by the Department of Public Health under
24 the Nursing Home Care Act as skilled nursing facilities or
25 intermediate care facilities, the Illinois Department shall
26 determine by rule the rates taking effect on July 1, 2002,

1 which shall be 5.9% less than the rates in effect on June 30,
2 2002.

3 Notwithstanding any other provision of this Section, for
4 facilities licensed by the Department of Public Health under
5 the Nursing Home Care Act as skilled nursing facilities or
6 intermediate care facilities, if the payment methodologies
7 required under Section 5A-12 and the waiver granted under 42
8 CFR 433.68 are approved by the United States Centers for
9 Medicare and Medicaid Services, the rates taking effect on July
10 1, 2004 shall be 3.0% greater than the rates in effect on June
11 30, 2004. These rates shall take effect only upon approval and
12 implementation of the payment methodologies required under
13 Section 5A-12.

14 Notwithstanding any other provisions 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 rates taking effect on
18 January 1, 2005 shall be 3% more than the rates in effect on
19 December 31, 2004.

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, effective January 1, 2009, the
24 per diem support component of the rates effective on January 1,
25 2008, computed using the most recent cost reports on file with
26 the Department of Healthcare and Family Services no later than

1 April 1, 2005, updated for inflation to January 1, 2006, shall
2 be increased to the amount that would have been derived using
3 standard Department of Healthcare and Family Services methods,
4 procedures, and inflators.

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 intermediate care facilities that
8 are federally defined as Institutions for Mental Disease, or
9 facilities licensed by the Department of Public Health under
10 the Specialized Mental Health Rehabilitation ~~Facilities~~ Act, a
11 socio-development component rate equal to 6.6% of the
12 facility's nursing component rate as of January 1, 2006 shall
13 be established and paid effective July 1, 2006. The
14 socio-development component of the rate shall be increased by a
15 factor of 2.53 on the first day of the month that begins at
16 least 45 days after January 11, 2008 (the effective date of
17 Public Act 95-707). As of August 1, 2008, the socio-development
18 component rate shall be equal to 6.6% of the facility's nursing
19 component rate as of January 1, 2006, multiplied by a factor of
20 3.53. For services provided on or after April 1, 2011, or the
21 first day of the month that begins at least 45 days after the
22 effective date of this amendatory Act of the 96th General
23 Assembly, whichever is later, the Illinois Department may by
24 rule adjust these socio-development component rates, and may
25 use different adjustment methodologies for those facilities
26 participating, and those not participating, in the Illinois

1 Department's demonstration program pursuant to the provisions
2 of Title 77, Part 300, Subpart T of the Illinois Administrative
3 Code, but in no case may such rates be diminished below those
4 in effect on August 1, 2008.

5 For facilities licensed by the Department of Public Health
6 under the Nursing Home Care Act as Intermediate Care for the
7 Developmentally Disabled facilities or as long-term care
8 facilities for residents under 22 years of age, the rates
9 taking effect on July 1, 2003 shall include a statewide
10 increase of 4%, as defined by the Department.

11 For facilities licensed by the Department of Public Health
12 under the Nursing Home Care Act as Intermediate Care for the
13 Developmentally Disabled facilities or Long Term Care for Under
14 Age 22 facilities, the rates taking effect on the first day of
15 the month that begins at least 45 days after the effective date
16 of this amendatory Act of the 95th General Assembly shall
17 include a statewide increase of 2.5%, as defined by the
18 Department.

19 Notwithstanding any other provision of this Section, for
20 facilities licensed by the Department of Public Health under
21 the Nursing Home Care Act as skilled nursing facilities or
22 intermediate care facilities, effective January 1, 2005,
23 facility rates shall be increased by the difference between (i)
24 a facility's per diem property, liability, and malpractice
25 insurance costs as reported in the cost report filed with the
26 Department of Public Aid and used to establish rates effective

1 July 1, 2001 and (ii) those same costs as reported in the
2 facility's 2002 cost report. These costs shall be passed
3 through to the facility without caps or limitations, except for
4 adjustments required under normal auditing procedures.

5 Rates established effective each July 1 shall govern
6 payment for services rendered throughout that fiscal year,
7 except that rates established on July 1, 1996 shall be
8 increased by 6.8% for services provided on or after January 1,
9 1997. Such rates will be based upon the rates calculated for
10 the year beginning July 1, 1990, and for subsequent years
11 thereafter until June 30, 2001 shall be based on the facility
12 cost reports for the facility fiscal year ending at any point
13 in time during the previous calendar year, updated to the
14 midpoint of the rate year. The cost report shall be on file
15 with the Department no later than April 1 of the current rate
16 year. Should the cost report not be on file by April 1, the
17 Department shall base the rate on the latest cost report filed
18 by each skilled care facility and intermediate care facility,
19 updated to the midpoint of the current rate year. In
20 determining rates for services rendered on and after July 1,
21 1985, fixed time shall not be computed at less than zero. The
22 Department shall not make any alterations of regulations which
23 would reduce any component of the Medicaid rate to a level
24 below what that component would have been utilizing in the rate
25 effective on July 1, 1984.

26 (2) Shall take into account the actual costs incurred by

1 facilities in providing services for recipients of skilled
2 nursing and intermediate care services under the medical
3 assistance program.

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

6 (4) Shall take into account the actual costs incurred by
7 facilities in meeting licensing and certification standards
8 imposed and prescribed by the State of Illinois, any of its
9 political subdivisions or municipalities and by the U.S.
10 Department of Health and Human Services pursuant to Title XIX
11 of the Social Security Act.

12 The Department of Healthcare and Family Services shall
13 develop precise standards for payments to reimburse nursing
14 facilities for any utilization of appropriate rehabilitative
15 personnel for the provision of rehabilitative services which is
16 authorized by federal regulations, including reimbursement for
17 services provided by qualified therapists or qualified
18 assistants, and which is in accordance with accepted
19 professional practices. Reimbursement also may be made for
20 utilization of other supportive personnel under appropriate
21 supervision.

22 The Department shall develop enhanced payments to offset
23 the additional costs incurred by a facility serving exceptional
24 need residents and shall allocate at least \$8,000,000 of the
25 funds collected from the assessment established by Section 5B-2
26 of this Code for such payments. For the purpose of this

1 Section, "exceptional needs" means, but need not be limited to,
2 ventilator care, tracheotomy care, bariatric care, complex
3 wound care, and traumatic brain injury care. The enhanced
4 payments for exceptional need residents under this paragraph
5 are not due and payable, however, until (i) the methodologies
6 described in this paragraph are approved by the federal
7 government in an appropriate State Plan amendment and (ii) the
8 assessment imposed by Section 5B-2 of this Code is determined
9 to be a permissible tax under Title XIX of the Social Security
10 Act.

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

16 ~~(6)~~ No payment increase under this Section for the MDS
17 methodology, exceptional care residents, or the
18 socio-development component rate established by Public Act
19 96-1530 of the 96th General Assembly and funded by the
20 assessment imposed under Section 5B-2 of this Code shall be due
21 and payable until after the Department notifies the long-term
22 care providers, in writing, that the payment methodologies to
23 long-term care providers required under this Section have been
24 approved by the Centers for Medicare and Medicaid Services of
25 the U.S. Department of Health and Human Services and the
26 waivers under 42 CFR 433.68 for the assessment imposed by this

1 Section, if necessary, have been granted by the Centers for
2 Medicare and Medicaid Services of the U.S. Department of Health
3 and Human Services. Upon notification to the Department of
4 approval of the payment methodologies required under this
5 Section and the waivers granted under 42 CFR 433.68, all
6 increased payments otherwise due under this Section prior to
7 the date of notification shall be due and payable within 90
8 days of the date federal approval is received.

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

14 (Source: P.A. 96-45, eff. 7-15-09; 96-339, eff. 7-1-10; 96-959,
15 eff. 7-1-10; 96-1000, eff. 7-2-10; 96-1530, eff. 2-16-11;
16 97-10, eff. 6-14-11; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12;
17 97-584, eff. 8-26-11; revised 10-4-11.)

18 (305 ILCS 5/5-5.4e)

19 Sec. 5-5.4e. Nursing facilities; ventilator rates. On and
20 after October 1, 2009, the Department of Healthcare and Family
21 Services shall adopt rules to provide medical assistance
22 reimbursement under this Article for the care of persons on
23 ventilators in skilled nursing facilities licensed under the
24 Nursing Home Care Act and certified to participate under the
25 medical assistance program. Accordingly, necessary amendments

1 to the rules implementing the Minimum Data Set (MDS) payment
2 methodology shall also be made to provide a separate per diem
3 ventilator rate based on days of service. The Department may
4 adopt rules necessary to implement this amendatory Act of the
5 96th General Assembly through the use of emergency rulemaking
6 in accordance with Section 5-45 of the Illinois Administrative
7 Procedure Act, except that the 24-month limitation on the
8 adoption of emergency rules under Section 5-45 and the
9 provisions of Sections 5-115 and 5-125 of that Act do not apply
10 to rules adopted under this Section. For purposes of that Act,
11 the General Assembly finds that the adoption of rules to
12 implement this amendatory Act of the 96th General Assembly is
13 deemed an emergency and necessary for the public interest,
14 safety, and welfare.

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. 96-743, eff. 8-25-09.)

21 (305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

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

23 (a) The Department of Healthcare and Family Services shall
24 develop a prospective method for determining payment rates for
25 nursing facility and ICF/DD services in nursing facilities

1 composed of the following cost elements:

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

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

10 (3) Ancillary Services, with the payment rate being
11 developed for each individual type of service. Payment
12 shall be made only when authorized under procedures
13 developed by the Department of Healthcare and Family
14 Services.

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

18 (5) Real Estate Taxes, with the cost of this component
19 being determined by taking into account the figures
20 contained in the most currently available cost reports
21 (with no imposition of maximums) updated to the midpoint of
22 the current rate year for long term care services rendered
23 between July 1, 1984 and June 30, 1985, and with the cost
24 of this component being determined by taking into account
25 the actual 1983 taxes for which the nursing homes were
26 assessed (with no imposition of maximums) updated to the

1 midpoint of the current rate year for long term care
2 services rendered between July 1, 1985 and June 30, 1986.

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

7 (1) Reasonable capital cost determined by utilizing
8 incurred interest rate and the current value of the
9 investment, including land, utilizing composite rates, or
10 by utilizing such other reasonable cost related methods
11 determined by the Department. However, beginning with the
12 rate reimbursement period effective July 1, 1987, the
13 Department shall be prohibited from establishing,
14 including, and implementing any depreciation factor in
15 calculating the capital cost element.

16 (2) Profit, with the actual amount being produced and
17 accruing to the providers in the form of a return on their
18 total investment, on the basis of their ability to
19 economically and efficiently deliver a type of service. The
20 method of payment may assure the opportunity for a profit,
21 but shall not guarantee or establish a specific amount as a
22 cost.

23 (c) The Illinois Department may implement the amendatory
24 changes to this Section made by this amendatory Act of 1991
25 through the use of emergency rules in accordance with the
26 provisions of Section 5.02 of the Illinois Administrative

1 Procedure Act. For purposes of the Illinois Administrative
2 Procedure Act, the adoption of rules to implement the
3 amendatory changes to this Section made by this amendatory Act
4 of 1991 shall be deemed an emergency and necessary for the
5 public interest, safety and welfare.

6 (d) No later than January 1, 2001, the Department of Public
7 Aid shall file with the Joint Committee on Administrative
8 Rules, pursuant to the Illinois Administrative Procedure Act, a
9 proposed rule, or a proposed amendment to an existing rule,
10 regarding payment for appropriate services, including
11 assessment, care planning, discharge planning, and treatment
12 provided by nursing facilities to residents who have a serious
13 mental illness.

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

19 (Source: P.A. 95-331, eff. 8-21-07; 96-1123, eff. 1-1-11;
20 96-1530, eff. 2-16-11.)

21 (305 ILCS 5/5-5.8b) (from Ch. 23, par. 5-5.8b)

22 Sec. 5-5.8b. Payment to Campus Facilities. There is hereby
23 established a separate payment category for campus facilities.
24 A "campus facility" is defined as an entity which consists of a
25 long term care facility (or group of facilities if the

1 facilities are on the same contiguous parcel of real estate)
2 which meets all of the following criteria as of May 1, 1987:
3 the entity provides care for both children and adults;
4 residents of the entity reside in three or more separate
5 buildings with congregate and small group living arrangements
6 on a single campus; the entity provides three or more separate
7 licensed levels of care; the entity (or a part of the entity)
8 is enrolled with the Department of Healthcare and Family
9 Services as a provider of long term care services and receives
10 payments from that Department; the entity (or a part of the
11 entity) receives funding from the Department of Human Services;
12 and the entity (or a part of the entity) holds a current
13 license as a child care institution issued by the Department of
14 Children and Family Services.

15 The Department of Healthcare and Family Services, the
16 Department of Human Services, and the Department of Children
17 and Family Services shall develop jointly a rate methodology or
18 methodologies for campus facilities. Such methodology or
19 methodologies may establish a single rate to be paid by all the
20 agencies, or a separate rate to be paid by each agency, or
21 separate components to be paid to different parts of the campus
22 facility. All campus facilities shall receive the same rate of
23 payment for similar services. Any methodology developed
24 pursuant to this section shall take into account the actual
25 costs to the facility of providing services to residents, and
26 shall be adequate to reimburse the allowable costs of a campus

1 facility which is economically and efficiently operated. Any
2 methodology shall be established on the basis of historical,
3 financial, and statistical data submitted by campus
4 facilities, and shall take into account the actual costs
5 incurred by campus facilities in providing services, and in
6 meeting licensing and certification standards imposed and
7 prescribed by the State of Illinois, any of its political
8 subdivisions or municipalities and by the United States
9 Department of Health and Human Services. Rates may be
10 established on a prospective or retrospective basis. Any
11 methodology shall provide reimbursement for appropriate
12 payment elements, including the following: standard services,
13 patient services, real estate taxes, and capital costs.

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

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

20 (305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

21 Sec. 5-5.12. Pharmacy payments.

22 (a) Every request submitted by a pharmacy for reimbursement
23 under this Article for prescription drugs provided to a
24 recipient of aid under this Article shall include the name of
25 the prescriber or an acceptable identification number as

1 established by the Department.

2 (b) Pharmacies providing prescription drugs under this
3 Article shall be reimbursed at a rate which shall include a
4 professional dispensing fee as determined by the Illinois
5 Department, plus the current acquisition cost of the
6 prescription drug dispensed. The Illinois Department shall
7 update its information on the acquisition costs of all
8 prescription drugs no less frequently than every 30 days.
9 However, the Illinois Department may set the rate of
10 reimbursement for the acquisition cost, by rule, at a
11 percentage of the current average wholesale acquisition cost.

12 (c) (Blank).

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

25 (e) When making determinations as to which drugs shall be
26 on a prior approval list, the Department shall include as part

1 of the analysis for this determination, the degree to which a
2 drug may affect individuals in different ways based on factors
3 including the gender of the person taking the medication.

4 (f) The Department shall cooperate with the Department of
5 Public Health and the Department of Human Services Division of
6 Mental Health in identifying psychotropic medications that,
7 when given in a particular form, manner, duration, or frequency
8 (including "as needed") in a dosage, or in conjunction with
9 other psychotropic medications to a nursing home resident or to
10 a resident of a facility licensed under the ID/DD ~~MR/DD~~
11 Community Care Act, may constitute a chemical restraint or an
12 "unnecessary drug" as defined by the Nursing Home Care Act or
13 Titles XVIII and XIX of the Social Security Act and the
14 implementing rules and regulations. The Department shall
15 require prior approval for any such medication prescribed for a
16 nursing home resident or to a resident of a facility licensed
17 under the ID/DD ~~MR/DD~~ Community Care Act, that appears to be a
18 chemical restraint or an unnecessary drug. The Department shall
19 consult with the Department of Human Services Division of
20 Mental Health in developing a protocol and criteria for
21 deciding whether to grant such prior approval.

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

26 (g-5) On and after July 1, 2012, the Department may require

1 the dispensing of drugs to nursing home residents be in a 7-day
2 supply or other amount less than a 31-day supply. The
3 Department shall pay only one dispensing fee per 31-day supply.

4 (h) Effective July 1, 2011, the Department shall
5 discontinue coverage of select over-the-counter drugs,
6 including analgesics and cough and cold and allergy
7 medications.

8 (h-5) On and after July 1, 2012, the Department shall
9 impose utilization controls, including, but not limited to,
10 prior approval on specialty drugs, oncolytic drugs, drugs for
11 the treatment of HIV or AIDS, immunosuppressant drugs, and
12 biological products in order to maximize savings on these
13 drugs. The Department may adjust payment methodologies for
14 non-pharmacy billed drugs in order to incentivize the selection
15 of lower-cost drugs. For drugs for the treatment of AIDS, the
16 Department shall take into consideration the potential for
17 non-adherence by certain populations, and shall develop
18 protocols with organizations or providers primarily serving
19 those with HIV/AIDS, as long as such measures intend to
20 maintain cost neutrality with other utilization management
21 controls such as prior approval. For hemophilia, the Department
22 shall develop a program of utilization review and control which
23 may include, in the discretion of the Department, prior
24 approvals. The Department may impose special standards on
25 providers that dispense blood factors which shall include, in
26 the discretion of the Department, staff training and education;

1 patient outreach and education; case management; in-home
2 patient assessments; assay management; maintenance of stock;
3 emergency dispensing timeframes; data collection and
4 reporting; dispensing of supplies related to blood factor
5 infusions; cold chain management and packaging practices; care
6 coordination; product recalls; and emergency clinical
7 consultation. The Department may require patients to receive a
8 comprehensive examination annually at an appropriate provider
9 in order to be eligible to continue to receive blood factor.

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

21 (j) On and after July 1, 2012, the Department shall impose
22 limitations on prescription drugs such that the Department
23 shall not provide reimbursement for more than 4 prescriptions,
24 including 3 brand name prescriptions, for distinct drugs in a
25 30-day period, unless prior approval is received for all
26 prescriptions in excess of the 4-prescription limit. Drugs in

1 the following therapeutic classes shall not be subject to prior
2 approval as a result of the 4-prescription limit:
3 immunosuppressant drugs, oncolytic drugs, and anti-retroviral
4 drugs.

5 (k) No medication therapy management program implemented
6 by the Department shall be contrary to the provisions of the
7 Pharmacy Practice Act.

8 (l) Any provider enrolled with the Department that bills
9 the Department for outpatient drugs and is eligible to enroll
10 in the federal Drug Pricing Program under Section 340B of the
11 federal Public Health Services Act shall enroll in that
12 program. No entity participating in the federal Drug Pricing
13 Program under Section 340B of the federal Public Health
14 Services Act may exclude Medicaid from their participation in
15 that program, although the Department may exclude entities
16 defined in Section 1905(1)(2)(B) of the Social Security Act
17 from this requirement.

18 (Source: P.A. 96-1269, eff. 7-26-10; 96-1372, eff. 7-29-10;
19 96-1501, eff. 1-25-11; 97-38, eff. 6-28-11; 97-74, eff.
20 6-30-11; 97-333, eff. 8-12-11; 97-426, eff. 1-1-12; revised
21 10-4-11.)

22 (305 ILCS 5/5-5.17) (from Ch. 23, par. 5-5.17)

23 Sec. 5-5.17. Separate reimbursement rate. The Illinois
24 Department may by rule establish a separate reimbursement rate
25 to be paid to long term care facilities for adult developmental

1 training services as defined in Section 15.2 of the Mental
2 Health and Developmental Disabilities Administrative Act which
3 are provided to intellectually disabled residents of such
4 facilities who receive aid under this Article. Any such
5 reimbursement shall be based upon cost reports submitted by the
6 providers of such services and shall be paid by the long term
7 care facility to the provider within such time as the Illinois
8 Department shall prescribe by rule, but in no case less than 3
9 business days after receipt of the reimbursement by such
10 facility from the Illinois Department. The Illinois Department
11 may impose a penalty upon a facility which does not make
12 payment to the provider of adult developmental training
13 services within the time so prescribed, up to the amount of
14 payment not made to the provider.

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. 97-227, eff. 1-1-12.)

21 (305 ILCS 5/5-5.20)

22 Sec. 5-5.20. Clinic payments. For services provided by
23 federally qualified health centers as defined in Section 1905
24 (1) (2) (B) of the federal Social Security Act, on or after April
25 1, 1989, and as long as required by federal law, the Illinois

1 Department shall reimburse those health centers for those
2 services according to a prospective cost-reimbursement
3 methodology.

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. 89-38, eff. 1-1-96.)

10 (305 ILCS 5/5-5.23)

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

12 (a) The Department of Healthcare and Family Services, by
13 rule, shall require the screening and assessment of a child
14 prior to any Medicaid-funded admission to an inpatient hospital
15 for psychiatric services to be funded by Medicaid. The
16 screening and assessment shall include a determination of the
17 appropriateness and availability of out-patient support
18 services for necessary treatment. The Department, by rule,
19 shall establish methods and standards of payment for the
20 screening, assessment, and necessary alternative support
21 services.

22 (b) The Department of Healthcare and Family Services, to
23 the extent allowable under federal law, shall secure federal
24 financial participation for Individual Care Grant expenditures
25 made by the Department of Human Services for the Medicaid

1 optional service authorized under Section 1905(h) of the
2 federal Social Security Act, pursuant to the provisions of
3 Section 7.1 of the Mental Health and Developmental Disabilities
4 Administrative Act.

5 (c) The Department of Healthcare and Family Services shall
6 work jointly with the Department of Human Services to implement
7 subsections (a) and (b).

8 (d) 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 Code to reduce any
11 rate of reimbursement for services or other payments in
12 accordance with Section 5-5e.

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

14 (305 ILCS 5/5-5.24)

15 Sec. 5-5.24. Prenatal and perinatal care. The Department of
16 Healthcare and Family Services may provide reimbursement under
17 this Article for all prenatal and perinatal health care
18 services that are provided for the purpose of preventing
19 low-birthweight infants, reducing the need for neonatal
20 intensive care hospital services, and promoting perinatal
21 health. These services may include comprehensive risk
22 assessments for pregnant women, women with infants, and
23 infants, lactation counseling, nutrition counseling,
24 childbirth support, psychosocial counseling, treatment and
25 prevention of periodontal disease, and other support services

1 that have been proven to improve birth outcomes. The Department
2 shall maximize the use of preventive prenatal and perinatal
3 health care services consistent with federal statutes, rules,
4 and regulations. The Department of Public Aid (now Department
5 of Healthcare and Family Services) shall develop a plan for
6 prenatal and perinatal preventive health care and shall present
7 the plan to the General Assembly by January 1, 2004. On or
8 before January 1, 2006 and every 2 years thereafter, the
9 Department shall report to the General Assembly concerning the
10 effectiveness of prenatal and perinatal health care services
11 reimbursed under this Section in preventing low-birthweight
12 infants and reducing the need for neonatal intensive care
13 hospital services. Each such report shall include an evaluation
14 of how the ratio of expenditures for treating low-birthweight
15 infants compared with the investment in promoting healthy
16 births and infants in local community areas throughout Illinois
17 relates to healthy infant development in those areas.

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.)

24 (305 ILCS 5/5-5.25)

25 Sec. 5-5.25. Access to psychiatric mental health services.

1 The General Assembly finds that providing access to psychiatric
2 mental health services in a timely manner will improve the
3 quality of life for persons suffering from mental illness and
4 will contain health care costs by avoiding the need for more
5 costly inpatient hospitalization. The Department of Healthcare
6 and Family Services shall reimburse psychiatrists and
7 federally qualified health centers as defined in Section
8 1905(1)(2)(B) of the federal Social Security Act for mental
9 health services provided by psychiatrists, as authorized by
10 Illinois law, to recipients via telepsychiatry. The
11 Department, by rule, shall establish (i) criteria for such
12 services to be reimbursed, including appropriate facilities
13 and equipment to be used at both sites and requirements for a
14 physician or other licensed health care professional to be
15 present at the site where the patient is located, and (ii) a
16 method to reimburse providers for mental health services
17 provided by telepsychiatry.

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. 95-16, eff. 7-18-07.)

24 (305 ILCS 5/5-5e new)

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

1 (a) Rates or payments for services in effect on June 30,
2 2012 shall be adjusted and services shall be affected as
3 required by any other provision of this amendatory Act of the
4 97th General Assembly. In addition, the Department shall do the
5 following:

6 (1) Delink the per diem rate paid for supportive living
7 facility services from the per diem rate paid for nursing
8 facility services, effective for services provided on or
9 after May 1, 2011.

10 (2) Cease payment for bed reserves in nursing
11 facilities, specialized mental health rehabilitation
12 facilities, and, except in the instance of residents who
13 are under 21 years of age, intermediate care facilities for
14 persons with developmental disabilities.

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

18 (b) After the application of subsection (a),
19 notwithstanding any other provision of this Code to the
20 contrary and to the extent permitted by federal law, on and
21 after July 1, 2012, the rates of reimbursement for services and
22 other payments provided under this Code shall further be
23 reduced as follows:

24 (1) Rates or payments for physician services, dental
25 services, or community health center services reimbursed
26 through an encounter rate, and services provided under the

1 Medicaid Rehabilitation Option of the Illinois Title XIX
2 State Plan shall not be further reduced.

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

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

10 (4) Rates or payments for hospital services delivered
11 by a Critical Access Hospital, which is an Illinois
12 hospital designated as a critical care hospital by the
13 Department of Public Health in accordance with 42 CFR 485,
14 Subpart F, shall not be further reduced.

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

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

22 (7) Rates or payments for services provided under
23 capitation rates shall be adjusted taking into
24 consideration the rates reduction and covered services
25 required by this amendatory Act of the 97th General
26 Assembly.

1 (8) For hospitals not previously described in this
2 subsection, the rates or payments for hospital services
3 shall be further reduced by 3.5%, except for payments
4 authorized under Section 5A-12.4 of this Code.

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

9 (c) Any assessment imposed by this Code shall continue and
10 nothing in this Section shall be construed to cause it to
11 cease.

12 (305 ILCS 5/5-5e.1 new)

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

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

15 (1) is licensed by the Department of Public Health as a
16 general acute care or pediatric hospital; and

17 (2) is a disproportionate share hospital, as described
18 in Section 1923 of the federal Social Security Act, as
19 determined by the Department; and

20 (3) meets one of the following:

21 (A) has a MIUR of at least 40% and a charity
22 percent of at least 4%; or

23 (B) has a MIUR of at least 50%.

24 (b) Definitions. As used in this Section:

25 (1) "Charity percent" means the ratio of (i) the

1 hospital's charity charges for services provided to
2 individuals without health insurance or another source of
3 third party coverage to (ii) the Illinois total hospital
4 charges, each as reported on the hospital's OBRA form.

5 (2) "MIUR" means Medicaid Inpatient Utilization Rate
6 and is defined as a fraction, the numerator of which is the
7 number of a hospital's inpatient days provided in the
8 hospital's fiscal year ending 3 years prior to the rate
9 year, to patients who, for such days, were eligible for
10 Medicaid under Title XIX of the federal Social Security
11 Act, 42 USC 1396a et seq., and the denominator of which is
12 the total number of the hospital's inpatient days in that
13 same period.

14 (3) "OBRA form" means form HFS-3834, OBRA '93 data
15 collection form, for the rate year.

16 (4) "Rate year" means the 12-month period beginning on
17 October 1.

18 (c) For the 27-month period beginning July 1, 2012, a
19 hospital that would have qualified for the rate year beginning
20 October 1, 2011, shall be a Safety-Net Hospital.

21 (d) No later than August 15 preceding the rate year, each
22 hospital shall submit the OBRA form to the Department. Prior to
23 October 1, the Department shall notify each hospital whether it
24 has qualified as a Safety-Net Hospital.

25 (e) The Department may promulgate rules in order to
26 implement this Section.

1 (305 ILCS 5/5-5f new)

2 Sec. 5-5f. Elimination and limitations of medical
3 assistance services. Notwithstanding any other provision of
4 this Code to the contrary, on and after July 1, 2012:

5 (a) The following services shall no longer be a covered
6 service available under this Code: group psychotherapy for
7 residents of any facility licensed under the Nursing Home Care
8 Act or the Specialized Mental Health Rehabilitation Act; and
9 adult chiropractic services.

10 (b) The Department shall place the following limitations on
11 services: (i) the Department shall limit adult eyeglasses to
12 one pair every 2 years; (ii) the Department shall set an annual
13 limit of a maximum of 20 visits for each of the following
14 services: adult speech, hearing, and language therapy
15 services, adult occupational therapy services, and physical
16 therapy services; (iii) the Department shall limit podiatry
17 services to individuals with diabetes; (iv) the Department
18 shall pay for caesarean sections at the normal vaginal delivery
19 rate unless a caesarean section was medically necessary; (v)
20 the Department shall limit adult dental services to
21 emergencies; and (vi) effective July 1, 2012, the Department
22 shall place limitations and require concurrent review on every
23 inpatient detoxification stay to prevent repeat admissions to
24 any hospital for detoxification within 60 days of a previous
25 inpatient detoxification stay. The Department shall convene a

1 workgroup of hospitals, substance abuse providers, care
2 coordination entities, managed care plans, and other
3 stakeholders to develop recommendations for quality standards,
4 diversion to other settings, and admission criteria for
5 patients who need inpatient detoxification.

6 (c) The Department shall require prior approval of the
7 following services: wheelchair repairs, regardless of the cost
8 of the repairs, coronary artery bypass graft, and bariatric
9 surgery consistent with Medicare standards concerning patient
10 responsibility. The wholesale cost of power wheelchairs shall
11 be actual acquisition cost including all discounts.

12 (d) The Department shall establish benchmarks for
13 hospitals to measure and align payments to reduce potentially
14 preventable hospital readmissions, inpatient complications,
15 and unnecessary emergency room visits. In doing so, the
16 Department shall consider items, including, but not limited to,
17 historic and current acuity of care and historic and current
18 trends in readmission. The Department shall publish
19 provider-specific historical readmission data and anticipated
20 potentially preventable targets 60 days prior to the start of
21 the program. In the instance of readmissions, the Department
22 shall adopt policies and rates of reimbursement for services
23 and other payments provided under this Code to ensure that, by
24 June 30, 2013, expenditures to hospitals are reduced by, at a
25 minimum, \$40,000,000.

26 (e) The Department shall establish utilization controls

1 for the hospice program such that it shall not pay for other
2 care services when an individual is in hospice.

3 (f) For home health services, the Department shall require
4 Medicare certification of providers participating in the
5 program, implement the Medicare face-to-face encounter rule,
6 and limit services to post-hospitalization. The Department
7 shall require providers to implement auditable electronic
8 service verification based on global positioning systems or
9 other cost-effective technology.

10 (g) For the Home Services Program operated by the
11 Department of Human Services and the Community Care Program
12 operated by the Department on Aging, the Department of Human
13 Services, in cooperation with the Department on Aging, shall
14 implement an electronic service verification based on global
15 positioning systems or other cost-effective technology.

16 (h) The Department shall not pay for hospital admissions
17 when the claim indicates a hospital acquired condition that
18 would cause Medicare to reduce its payment on the claim had the
19 claim been submitted to Medicare, nor shall the Department pay
20 for hospital admissions where a Medicare identified "never
21 event" occurred.

22 (i) The Department shall implement cost savings
23 initiatives for advanced imaging services, cardiac imaging
24 services, pain management services, and back surgery. Such
25 initiatives shall be designed to achieve annual costs savings.

1 (305 ILCS 5/5-16.7)

2 Sec. 5-16.7. Post-parturition care. The medical assistance
3 program shall provide the post-parturition care benefits
4 required to be covered by a policy of accident and health
5 insurance under Section 356s of the Illinois Insurance Code.

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. 89-513, eff. 9-15-96; 90-14, eff. 7-1-97.)

12 (305 ILCS 5/5-16.7a)

13 Sec. 5-16.7a. Reimbursement for epidural anesthesia
14 services. In addition to other procedures authorized by the
15 Department under this Code, the Department shall provide
16 reimbursement to medical providers for epidural anesthesia
17 services when ordered by the attending practitioner at the time
18 of delivery.

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

24 (Source: P.A. 93-981, eff. 8-23-04.)

1 (305 ILCS 5/5-16.8)

2 Sec. 5-16.8. Required health benefits. The medical
3 assistance program shall (i) provide the post-mastectomy care
4 benefits required to be covered by a policy of accident and
5 health insurance under Section 356t and the coverage required
6 under Sections 356g.5, 356u, 356w, 356x, and 356z.6 of the
7 Illinois Insurance Code and (ii) be subject to the provisions
8 of Sections 356z.19 and 364.01 of the Illinois Insurance Code.

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

14 (Source: P.A. 97-282, eff. 8-9-11.)

15 (305 ILCS 5/5-16.9)

16 Sec. 5-16.9. Woman's health care provider. The medical
17 assistance program is subject to the provisions of Section 356r
18 of the Illinois Insurance Code. The Illinois Department shall
19 adopt rules to implement the requirements of Section 356r of
20 the Illinois Insurance Code in the medical assistance program
21 including managed care components.

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

1 Section 5-5e.

2 (Source: P.A. 92-370, eff. 8-15-01.)

3 (305 ILCS 5/5-17) (from Ch. 23, par. 5-17)

4 Sec. 5-17. Programs to improve access to hospital care.

5 (a) (1) The General Assembly finds:

6 (A) That while hospitals have traditionally
7 provided charitable care to indigent patients, this
8 burden is not equally borne by all hospitals operating
9 in this State. Some hospitals continue to provide
10 significant amounts of care to low-income persons
11 while others provide very little such care; and

12 (B) That access to hospital care in this State by
13 the indigent citizens of Illinois would be seriously
14 impaired by the closing of hospitals that provide
15 significant amounts of care to low-income persons.

16 (2) To help expand the availability of hospital care
17 for all citizens of this State, it is the policy of the
18 State to implement programs that more equitably distribute
19 the burden of providing hospital care to Illinois'
20 low-income population and that improve access to health
21 care in Illinois.

22 (3) The Illinois Department may develop and implement a
23 program that lessens the burden of providing hospital care
24 to Illinois' low-income population, taking into account
25 the costs that must be incurred by hospitals providing

1 significant amounts of care to low-income persons, and may
2 develop adjustments to increase rates to improve access to
3 health care in Illinois. The Illinois Department shall
4 prescribe by rule the criteria, standards and procedures
5 for effecting such adjustments in the rates of hospital
6 payments for services provided to eligible low-income
7 persons (under Articles V, VI and VII of this Code) under
8 this Article.

9 (b) The Illinois Department shall require hospitals
10 certified to participate in the federal Medicaid program to:

11 (1) provide equal access to available services to
12 low-income persons who are eligible for assistance under
13 Articles V, VI and VII of this Code;

14 (2) provide data and reports on the provision of
15 uncompensated care.

16 (c) From the effective date of this amendatory Act of 1992
17 until July 1, 1992, nothing in this Section 5-17 shall be
18 construed as creating a private right of action on behalf of
19 any individual.

20 (d) 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 Code to reduce any
23 rate of reimbursement for services or other payments in
24 accordance with Section 5-5e.

25 (Source: P.A. 87-13; 87-838.)

1 (305 ILCS 5/5-19) (from Ch. 23, par. 5-19)

2 Sec. 5-19. Healthy Kids Program.

3 (a) Any child under the age of 21 eligible to receive
4 Medical Assistance from the Illinois Department under Article V
5 of this Code shall be eligible for Early and Periodic
6 Screening, Diagnosis and Treatment services provided by the
7 Healthy Kids Program of the Illinois Department under the
8 Social Security Act, 42 U.S.C. 1396d(r).

9 (b) Enrollment of Children in Medicaid. The Illinois
10 Department shall provide for receipt and initial processing of
11 applications for Medical Assistance for all pregnant women and
12 children under the age of 21 at locations in addition to those
13 used for processing applications for cash assistance,
14 including disproportionate share hospitals, federally
15 qualified health centers and other sites as selected by the
16 Illinois Department.

17 (c) Healthy Kids Examinations. The Illinois Department
18 shall consider any examination of a child eligible for the
19 Healthy Kids services provided by a medical provider meeting
20 the requirements and complying with the rules and regulations
21 of the Illinois Department to be reimbursed as a Healthy Kids
22 examination.

23 (d) Medical Screening Examinations.

24 (1) The Illinois Department shall insure Medicaid
25 coverage for periodic health, vision, hearing, and dental
26 screenings for children eligible for Healthy Kids services

1 scheduled from a child's birth up until the child turns 21
2 years. The Illinois Department shall pay for vision,
3 hearing, dental and health screening examinations for any
4 child eligible for Healthy Kids services by qualified
5 providers at intervals established by Department rules.

6 (2) The Illinois Department shall pay for an
7 interperiodic health, vision, hearing, or dental screening
8 examination for any child eligible for Healthy Kids
9 services whenever an examination is:

10 (A) requested by a child's parent, guardian, or
11 custodian, or is determined to be necessary or
12 appropriate by social services, developmental, health,
13 or educational personnel; or

14 (B) necessary for enrollment in school; or

15 (C) necessary for enrollment in a licensed day care
16 program, including Head Start; or

17 (D) necessary for placement in a licensed child
18 welfare facility, including a foster home, group home
19 or child care institution; or

20 (E) necessary for attendance at a camping program;
21 or

22 (F) necessary for participation in an organized
23 athletic program; or

24 (G) necessary for enrollment in an early childhood
25 education program recognized by the Illinois State
26 Board of Education; or

1 (H) necessary for participation in a Women,
2 Infant, and Children (WIC) program; or

3 (I) deemed appropriate by the Illinois Department.

4 (e) Minimum Screening Protocols For Periodic Health
5 Screening Examinations. Health Screening Examinations must
6 include the following services:

7 (1) Comprehensive Health and Development Assessment
8 including:

9 (A) Development/Mental Health/Psychosocial
10 Assessment; and

11 (B) Assessment of nutritional status including
12 tests for iron deficiency and anemia for children at
13 the following ages: 9 months, 2 years, 8 years, and 18
14 years;

15 (2) Comprehensive unclothed physical exam;

16 (3) Appropriate immunizations at a minimum, as
17 required by the Secretary of the U.S. Department of Health
18 and Human Services under 42 U.S.C. 1396d(r).

19 (4) Appropriate laboratory tests including blood lead
20 levels appropriate for age and risk factors.

21 (A) Anemia test.

22 (B) Sickle cell test.

23 (C) Tuberculin test at 12 months of age and every
24 1-2 years thereafter unless the treating health care
25 professional determines that testing is medically
26 contraindicated.

1 (D) Other -- The Illinois Department shall insure
2 that testing for HIV, drug exposure, and sexually
3 transmitted diseases is provided for as clinically
4 indicated.

5 (5) Health Education. The Illinois Department shall
6 require providers to provide anticipatory guidance as
7 recommended by the American Academy of Pediatrics.

8 (6) Vision Screening. The Illinois Department shall
9 require providers to provide vision screenings consistent
10 with those set forth in the Department of Public Health's
11 Administrative Rules.

12 (7) Hearing Screening. The Illinois Department shall
13 require providers to provide hearing screenings consistent
14 with those set forth in the Department of Public Health's
15 Administrative Rules.

16 (8) Dental Screening. The Illinois Department shall
17 require providers to provide dental screenings consistent
18 with those set forth in the Department of Public Health's
19 Administrative Rules.

20 (f) Covered Medical Services. The Illinois Department
21 shall provide coverage for all necessary health care,
22 diagnostic services, treatment and other measures to correct or
23 ameliorate defects, physical and mental illnesses, and
24 conditions whether discovered by the screening services or not
25 for all children eligible for Medical Assistance under Article
26 V of this Code.

1 (g) Notice of Healthy Kids Services.

2 (1) The Illinois Department shall inform any child
3 eligible for Healthy Kids services and the child's family
4 about the benefits provided under the Healthy Kids Program,
5 including, but not limited to, the following: what services
6 are available under Healthy Kids, including discussion of
7 the periodicity schedules and immunization schedules, that
8 services are provided at no cost to eligible children, the
9 benefits of preventive health care, where the services are
10 available, how to obtain them, and that necessary
11 transportation and scheduling assistance is available.

12 (2) The Illinois Department shall widely disseminate
13 information regarding the availability of the Healthy Kids
14 Program throughout the State by outreach activities which
15 shall include, but not be limited to, (i) the development
16 of cooperation agreements with local school districts,
17 public health agencies, clinics, hospitals and other
18 health care providers, including developmental disability
19 and mental health providers, and with charities, to notify
20 the constituents of each of the Program and assist
21 individuals, as feasible, with applying for the Program,
22 (ii) using the media for public service announcements and
23 advertisements of the Program, and (iii) developing
24 posters advertising the Program for display in hospital and
25 clinic waiting rooms.

26 (3) The Illinois Department shall utilize accepted

1 methods for informing persons who are illiterate, blind,
2 deaf, or cannot understand the English language, including
3 but not limited to public services announcements and
4 advertisements in the foreign language media of radio,
5 television and newspapers.

6 (4) The Illinois Department shall provide notice of the
7 Healthy Kids Program to every child eligible for Healthy
8 Kids services and his or her family at the following times:

9 (A) orally by the intake worker and in writing at
10 the time of application for Medical Assistance;

11 (B) at the time the applicant is informed that he
12 or she is eligible for Medical Assistance benefits; and

13 (C) at least 20 days before the date of any
14 periodic health, vision, hearing, and dental
15 examination for any child eligible for Healthy Kids
16 services. Notice given under this subparagraph (C)
17 must state that a screening examination is due under
18 the periodicity schedules and must advise the eligible
19 child and his or her family that the Illinois
20 Department will provide assistance in scheduling an
21 appointment and arranging medical transportation.

22 (h) Data Collection. The Illinois Department shall collect
23 data in a usable form to track utilization of Healthy Kids
24 screening examinations by children eligible for Healthy Kids
25 services, including but not limited to data showing screening
26 examinations and immunizations received, a summary of

1 follow-up treatment received by children eligible for Healthy
2 Kids services and the number of children receiving dental,
3 hearing and vision services.

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

9 (Source: P.A. 87-630; 87-895.)

10 (305 ILCS 5/5-24)

11 (Section scheduled to be repealed on January 1, 2014)

12 Sec. 5-24. Disease management programs and services for
13 chronic conditions; pilot project.

14 (a) In this Section, "disease management programs and
15 services" means services administered to patients in order to
16 improve their overall health and to prevent clinical
17 exacerbations and complications, using cost-effective,
18 evidence-based practice guidelines and patient self-management
19 strategies. Disease management programs and services include
20 all of the following:

21 (1) A population identification process.

22 (2) Evidence-based or consensus-based clinical
23 practice guidelines, risk identification, and matching of
24 interventions with clinical need.

25 (3) Patient self-management and disease education.

1 (4) Process and outcomes measurement, evaluation,
2 management, and reporting.

3 (b) Subject to appropriations, the Department of
4 Healthcare and Family Services may undertake a pilot project to
5 study patient outcomes, for patients with chronic diseases or
6 patients at risk of low birth weight or premature birth,
7 associated with the use of disease management programs and
8 services for chronic condition management. "Chronic diseases"
9 include, but are not limited to, diabetes, congestive heart
10 failure, and chronic obstructive pulmonary disease. Low birth
11 weight and premature birth include all medical and other
12 conditions that lead to poor birth outcomes or problematic
13 pregnancies.

14 (c) The disease management programs and services pilot
15 project shall examine whether chronic disease management
16 programs and services for patients with specific chronic
17 conditions do any or all of the following:

18 (1) Improve the patient's overall health in a more
19 expeditious manner.

20 (2) Lower costs in other aspects of the medical
21 assistance program, such as hospital admissions, days in
22 skilled nursing homes, emergency room visits, or more
23 frequent physician office visits.

24 (d) In carrying out the pilot project, the Department of
25 Healthcare and Family Services shall examine all relevant
26 scientific literature and shall consult with health care

1 practitioners including, but not limited to, physicians,
2 surgeons, registered pharmacists, and registered nurses.

3 (e) The Department of Healthcare and Family Services shall
4 consult with medical experts, disease advocacy groups, and
5 academic institutions to develop criteria to be used in
6 selecting a vendor for the pilot project.

7 (f) The Department of Healthcare and Family Services may
8 adopt rules to implement this Section.

9 (g) This Section is repealed 10 years after the effective
10 date of this amendatory Act of the 93rd General Assembly.

11 (h) 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. 95-331, eff. 8-21-07; 96-799, eff. 10-28-09.)

17 (305 ILCS 5/5-30)

18 Sec. 5-30. Care coordination.

19 (a) At least 50% of recipients eligible for comprehensive
20 medical benefits in all medical assistance programs or other
21 health benefit programs administered by the Department,
22 including the Children's Health Insurance Program Act and the
23 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
24 care coordination program by no later than January 1, 2015. For
25 purposes of this Section, "coordinated care" or "care

1 coordination" means delivery systems where recipients will
2 receive their care from providers who participate under
3 contract in integrated delivery systems that are responsible
4 for providing or arranging the majority of care, including
5 primary care physician services, referrals from primary care
6 physicians, diagnostic and treatment services, behavioral
7 health services, in-patient and outpatient hospital services,
8 dental services, and rehabilitation and long-term care
9 services. The Department shall designate or contract for such
10 integrated delivery systems (i) to ensure enrollees have a
11 choice of systems and of primary care providers within such
12 systems; (ii) to ensure that enrollees receive quality care in
13 a culturally and linguistically appropriate manner; and (iii)
14 to ensure that coordinated care programs meet the diverse needs
15 of enrollees with developmental, mental health, physical, and
16 age-related disabilities.

17 (b) Payment for such coordinated care shall be based on
18 arrangements where the State pays for performance related to
19 health care outcomes, the use of evidence-based practices, the
20 use of primary care delivered through comprehensive medical
21 homes, the use of electronic medical records, and the
22 appropriate exchange of health information electronically made
23 either on a capitated basis in which a fixed monthly premium
24 per recipient is paid and full financial risk is assumed for
25 the delivery of services, or through other risk-based payment
26 arrangements.

1 (c) To qualify for compliance with this Section, the 50%
2 goal shall be achieved by enrolling medical assistance
3 enrollees from each medical assistance enrollment category,
4 including parents, children, seniors, and people with
5 disabilities to the extent that current State Medicaid payment
6 laws would not limit federal matching funds for recipients in
7 care coordination programs. In addition, services must be more
8 comprehensively defined and more risk shall be assumed than in
9 the Department's primary care case management program as of the
10 effective date of this amendatory Act of the 96th General
11 Assembly.

12 (d) The Department shall report to the General Assembly in
13 a separate part of its annual medical assistance program
14 report, beginning April, 2012 until April, 2016, on the
15 progress and implementation of the care coordination program
16 initiatives established by the provisions of this amendatory
17 Act of the 96th General Assembly. The Department shall include
18 in its April 2011 report a full analysis of federal laws or
19 regulations regarding upper payment limitations to providers
20 and the necessary revisions or adjustments in rate
21 methodologies and payments to providers under this Code that
22 would be necessary to implement coordinated care with full
23 financial risk by a party other than the Department.

24 (e) Integrated Care Program for individuals with chronic
25 mental health conditions.

26 (1) The Integrated Care Program shall encompass

1 services administered to recipients of medical assistance
2 under this Article to prevent exacerbations and
3 complications using cost-effective, evidence-based
4 practice guidelines and mental health management
5 strategies.

6 (2) The Department may utilize and expand upon existing
7 contractual arrangements with integrated care plans under
8 the Integrated Care Program for providing the coordinated
9 care provisions of this Section.

10 (3) Payment for such coordinated care shall be based on
11 arrangements where the State pays for performance related
12 to mental health outcomes on a capitated basis in which a
13 fixed monthly premium per recipient is paid and full
14 financial risk is assumed for the delivery of services, or
15 through other risk-based payment arrangements such as
16 provider-based care coordination.

17 (4) The Department shall examine whether chronic
18 mental health management programs and services for
19 recipients with specific chronic mental health conditions
20 do any or all of the following:

21 (A) Improve the patient's overall mental health in
22 a more expeditious and cost-effective manner.

23 (B) Lower costs in other aspects of the medical
24 assistance program, such as hospital admissions,
25 emergency room visits, or more frequent and
26 inappropriate psychotropic drug use.

1 (5) The Department shall work with the facilities and
2 any integrated care plan participating in the program to
3 identify and correct barriers to the successful
4 implementation of this subsection (e) prior to and during
5 the implementation to best facilitate the goals and
6 objectives of this subsection (e).

7 (f) A hospital that is located in a county of the State in
8 which the Department mandates some or all of the beneficiaries
9 of the Medical Assistance Program residing in the county to
10 enroll in a Care Coordination Program, as set forth in Section
11 5-30 of this Code, shall not be eligible for any non-claims
12 based payments not mandated by Article V-A of this Code for
13 which it would otherwise be qualified to receive, unless the
14 hospital is a Coordinated Care Participating Hospital no later
15 than 60 days after the effective date of this amendatory Act of
16 the 97th General Assembly or 60 days after the first mandatory
17 enrollment of a beneficiary in a Coordinated Care program. For
18 purposes of this subsection, "Coordinated Care Participating
19 Hospital" means a hospital that meets one of the following
20 criteria:

21 (1) The hospital has entered into a contract to provide
22 hospital services to enrollees of the care coordination
23 program.

24 (2) The hospital has not been offered a contract by a
25 care coordination plan that pays at least as much as the
26 Department would pay, on a fee-for-service basis, not

1 including disproportionate share hospital adjustment
2 payments or any other supplemental adjustment or add-on
3 payment to the base fee-for-service rate.

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

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

6 Sec. 5A-1. Definitions. As used in this Article, unless
7 the context requires otherwise:

8 ~~"Adjusted gross hospital revenue" shall be determined~~
9 ~~separately for inpatient and outpatient services for each~~
10 ~~hospital conducted, operated or maintained by a hospital~~
11 ~~provider, and means the hospital provider's total gross~~
12 ~~revenues less: (i) gross revenue attributable to non-hospital~~
13 ~~based services including home dialysis services, durable~~
14 ~~medical equipment, ambulance services, outpatient clinics and~~
15 ~~any other non hospital based services as determined by the~~
16 ~~Illinois Department by rule; and (ii) gross revenues~~
17 ~~attributable to the routine services provided to persons~~
18 ~~receiving skilled or intermediate long term care services~~
19 ~~within the meaning of Title XVIII or XIX of the Social Security~~
20 ~~Act; and (iii) Medicare gross revenue (excluding the Medicare~~
21 ~~gross revenue attributable to clauses (i) and (ii) of this~~
22 ~~paragraph and the Medicare gross revenue attributable to the~~
23 ~~routine services provided to patients in a psychiatric~~
24 ~~hospital, a rehabilitation hospital, a distinct part~~
25 ~~psychiatric unit, a distinct part rehabilitation unit, or swing~~

1 ~~beds). Adjusted gross hospital revenue shall be determined~~
2 ~~using the most recent data available from each hospital's 2003~~
3 ~~Medicare cost report as contained in the Healthcare Cost Report~~
4 ~~Information System file, for the quarter ending on December 31,~~
5 ~~2004, without regard to any subsequent adjustments or changes~~
6 ~~to such data. If a hospital's 2003 Medicare cost report is not~~
7 ~~contained in the Healthcare Cost Report Information System, the~~
8 ~~hospital provider shall furnish such cost report or the data~~
9 ~~necessary to determine its adjusted gross hospital revenue as~~
10 ~~required by rule by the Illinois Department.~~

11 "Fund" means the Hospital Provider Fund.

12 "Hospital" means an institution, place, building, or
13 agency located in this State that is subject to licensure by
14 the Illinois Department of Public Health under the Hospital
15 Licensing Act, whether public or private and whether organized
16 for profit or not-for-profit.

17 "Hospital provider" means a person licensed by the
18 Department of Public Health to conduct, operate, or maintain a
19 hospital, regardless of whether the person is a Medicaid
20 provider. For purposes of this paragraph, "person" means any
21 political subdivision of the State, municipal corporation,
22 individual, firm, partnership, corporation, company, limited
23 liability company, association, joint stock association, or
24 trust, or a receiver, executor, trustee, guardian, or other
25 representative appointed by order of any court.

26 "Medicare bed days" means, for each hospital, the sum of

1 the number of days that each bed was occupied by a patient who
2 was covered by Title XVIII of the Social Security Act,
3 excluding days attributable to the routine services provided to
4 persons receiving skilled or intermediate long term care
5 services. Medicare bed days shall be computed separately for
6 each hospital operated or maintained by a hospital provider.

7 "Occupied bed days" means the sum of the number of days
8 that each bed was occupied by a patient for all beds, excluding
9 days attributable to the routine services provided to persons
10 receiving skilled or intermediate long term care services.
11 Occupied bed days shall be computed separately for each
12 hospital operated or maintained by a hospital provider.

13 ~~"Proration factor" means a fraction, the numerator of which~~
14 ~~is 53 and the denominator of which is 365.~~

15 (Source: P.A. 94-242, eff. 7-18-05; 95-859, eff. 8-19-08.)

16 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

17 (Section scheduled to be repealed on July 1, 2014)

18 Sec. 5A-2. Assessment.

19 (a) ~~Subject to Sections 5A-3 and 5A-10, an annual~~
20 ~~assessment on inpatient services is imposed on each hospital~~
21 ~~provider in an amount equal to the hospital's occupied bed days~~
22 ~~multiplied by \$84.19 multiplied by the proration factor for~~
23 ~~State fiscal year 2004 and the hospital's occupied bed days~~
24 ~~multiplied by \$84.19 for State fiscal year 2005.~~

25 ~~For State fiscal years 2004 and 2005, the Department of~~

1 ~~Healthcare and Family Services shall use the number of occupied~~
2 ~~bed days as reported by each hospital on the Annual Survey of~~
3 ~~Hospitals conducted by the Department of Public Health to~~
4 ~~calculate the hospital's annual assessment. If the sum of a~~
5 ~~hospital's occupied bed days is not reported on the Annual~~
6 ~~Survey of Hospitals or if there are data errors in the reported~~
7 ~~sum of a hospital's occupied bed days as determined by the~~
8 ~~Department of Healthcare and Family Services (formerly~~
9 ~~Department of Public Aid), then the Department of Healthcare~~
10 ~~and Family Services may obtain the sum of occupied bed days~~
11 ~~from any source available, including, but not limited to,~~
12 ~~records maintained by the hospital provider, which may be~~
13 ~~inspected at all times during business hours of the day by the~~
14 ~~Department of Healthcare and Family Services or its duly~~
15 ~~authorized agents and employees.~~

16 ~~Subject to Sections 5A-3 and 5A-10, for the privilege of~~
17 ~~engaging in the occupation of hospital provider, beginning~~
18 ~~August 1, 2005, an annual assessment is imposed on each~~
19 ~~hospital provider for State fiscal years 2006, 2007, and 2008,~~
20 ~~in an amount equal to 2.5835% of the hospital provider's~~
21 ~~adjusted gross hospital revenue for inpatient services and~~
22 ~~2.5835% of the hospital provider's adjusted gross hospital~~
23 ~~revenue for outpatient services. If the hospital provider's~~
24 ~~adjusted gross hospital revenue is not available, then the~~
25 ~~Illinois Department may obtain the hospital provider's~~
26 ~~adjusted gross hospital revenue from any source available,~~

1 ~~including, but not limited to, records maintained by the~~
2 ~~hospital provider, which may be inspected at all times during~~
3 ~~business hours of the day by the Illinois Department or its~~
4 ~~duly authorized agents and employees.~~

5 Subject to Sections 5A-3 and 5A-10, for State fiscal years
6 2009 through 2014 and July 1, 2014 through December 31, 2014,
7 an annual assessment on inpatient services is imposed on each
8 hospital provider in an amount equal to \$218.38 multiplied by
9 the difference of the hospital's occupied bed days less the
10 hospital's Medicare bed days.

11 For State fiscal years 2009 through 2014 and after, a
12 hospital's occupied bed days and Medicare bed days shall be
13 determined using the most recent data available from each
14 hospital's 2005 Medicare cost report as contained in the
15 Healthcare Cost Report Information System file, for the quarter
16 ending on December 31, 2006, without regard to any subsequent
17 adjustments or changes to such data. If a hospital's 2005
18 Medicare cost report is not contained in the Healthcare Cost
19 Report Information System, then the Illinois Department may
20 obtain the hospital provider's occupied bed days and Medicare
21 bed days from any source available, including, but not limited
22 to, records maintained by the hospital provider, which may be
23 inspected at all times during business hours of the day by the
24 Illinois Department or its duly authorized agents and
25 employees.

26 (b) (Blank).

1 (c) (Blank).

2 (d) Notwithstanding any of the other provisions of this
3 Section, the Department is authorized, ~~during this 94th General~~
4 ~~Assembly,~~ to adopt rules to reduce the rate of any annual
5 assessment imposed under this Section, as authorized by Section
6 5-46.2 of the Illinois Administrative Procedure Act.

7 (e) Notwithstanding any other provision of this Section,
8 any plan providing for an assessment on a hospital provider as
9 a permissible tax under Title XIX of the federal Social
10 Security Act and Medicaid-eligible payments to hospital
11 providers from the revenues derived from that assessment shall
12 be reviewed by the Illinois Department of Healthcare and Family
13 Services, as the Single State Medicaid Agency required by
14 federal law, to determine whether those assessments and
15 hospital provider payments meet federal Medicaid standards. If
16 the Department determines that the elements of the plan may
17 meet federal Medicaid standards and a related State Medicaid
18 Plan Amendment is prepared in a manner and form suitable for
19 submission, that State Plan Amendment shall be submitted in a
20 timely manner for review by the Centers for Medicare and
21 Medicaid Services of the United States Department of Health and
22 Human Services and subject to approval by the Centers for
23 Medicare and Medicaid Services of the United States Department
24 of Health and Human Services. No such plan shall become
25 effective without approval by the Illinois General Assembly by
26 the enactment into law of related legislation. Notwithstanding

1 any other provision of this Section, the Department is
2 authorized to adopt rules to reduce the rate of any annual
3 assessment imposed under this Section. Any such rules may be
4 adopted by the Department under Section 5-50 of the Illinois
5 Administrative Procedure Act.

6 (Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

7 (305 ILCS 5/5A-3) (from Ch. 23, par. 5A-3)

8 Sec. 5A-3. Exemptions.

9 (a) (Blank).

10 (b) A hospital provider that is a State agency, a State
11 university, or a county with a population of 3,000,000 or more
12 is exempt from the assessment imposed by Section 5A-2.

13 (b-2) A hospital provider that is a county with a
14 population of less than 3,000,000 or a township, municipality,
15 hospital district, or any other local governmental unit is
16 exempt from the assessment imposed by Section 5A-2.

17 (b-5) (Blank).

18 (b-10) (Blank). ~~For State fiscal years 2004 through 2014, a~~
19 ~~hospital provider, described in Section 1903(w)(3)(F) of the~~
20 ~~Social Security Act, whose hospital does not charge for its~~
21 ~~services is exempt from the assessment imposed by Section 5A-2,~~
22 ~~unless the exemption is adjudged to be unconstitutional or~~
23 ~~otherwise invalid, in which case the hospital provider shall~~
24 ~~pay the assessment imposed by Section 5A-2.~~

25 (b-15) (Blank). ~~For State fiscal years 2004 and 2005, a~~

1 ~~hospital provider whose hospital is licensed by the Department~~
2 ~~of Public Health as a psychiatric hospital is exempt from the~~
3 ~~assessment imposed by Section 5A-2, unless the exemption is~~
4 ~~adjudged to be unconstitutional or otherwise invalid, in which~~
5 ~~case the hospital provider shall pay the assessment imposed by~~
6 ~~Section 5A-2.~~

7 (b-20) (Blank). ~~For State fiscal years 2004 and 2005, a~~
8 ~~hospital provider whose hospital is licensed by the Department~~
9 ~~of Public Health as a rehabilitation hospital is exempt from~~
10 ~~the assessment imposed by Section 5A-2, unless the exemption is~~
11 ~~adjudged to be unconstitutional or otherwise invalid, in which~~
12 ~~case the hospital provider shall pay the assessment imposed by~~
13 ~~Section 5A-2.~~

14 (b-25) (Blank). ~~For State fiscal years 2004 and 2005, a~~
15 ~~hospital provider whose hospital (i) is not a psychiatric~~
16 ~~hospital, rehabilitation hospital, or children's hospital and~~
17 ~~(ii) has an average length of inpatient stay greater than 25~~
18 ~~days is exempt from the assessment imposed by Section 5A-2,~~
19 ~~unless the exemption is adjudged to be unconstitutional or~~
20 ~~otherwise invalid, in which case the hospital provider shall~~
21 ~~pay the assessment imposed by Section 5A-2.~~

22 (c) (Blank).

23 (Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

24 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

25 Sec. 5A-4. Payment of assessment; penalty.

1 (a) The ~~The annual assessment imposed by Section 5A-2 for~~
2 ~~State fiscal year 2004 shall be due and payable on June 18 of~~
3 ~~the year. The assessment imposed by Section 5A-2 for State~~
4 ~~fiscal year 2005 shall be due and payable in quarterly~~
5 ~~installments, each equalling one fourth of the assessment for~~
6 ~~the year, on July 19, October 19, January 18, and April 19 of~~
7 ~~the year. The assessment imposed by Section 5A-2 for State~~
8 ~~fiscal years 2006 through 2008 shall be due and payable in~~
9 ~~quarterly installments, each equaling one fourth of the~~
10 ~~assessment for the year, on the fourteenth State business day~~
11 ~~of September, December, March, and May. Except as provided in~~
12 ~~subsection (a-5) of this Section, the assessment imposed by~~
13 Section 5A-2 for State fiscal year 2009 and each subsequent
14 State fiscal year shall be due and payable in monthly
15 installments, each equaling one-twelfth of the assessment for
16 the year, on the fourteenth State business day of each month.
17 No installment payment of an assessment imposed by Section 5A-2
18 shall be due and payable, however, until after the Comptroller
19 has issued the payments required under this Article. ~~:(i) the~~
20 ~~Department notifies the hospital provider, in writing, that the~~
21 ~~payment methodologies to hospitals required under Section~~
22 ~~5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is~~
23 ~~applicable for that fiscal year, have been approved by the~~
24 ~~Centers for Medicare and Medicaid Services of the U.S.~~
25 ~~Department of Health and Human Services and the waiver under 42~~
26 ~~CFR 433.68 for the assessment imposed by Section 5A 2, if~~

1 ~~necessary, has been granted by the Centers for Medicare and~~
2 ~~Medicaid Services of the U.S. Department of Health and Human~~
3 ~~Services; and (ii) the Comptroller has issued the payments~~
4 ~~required under Section 5A-12, Section 5A-12.1, or Section~~
5 ~~5A-12.2, whichever is applicable for that fiscal year. Upon~~
6 ~~notification to the Department of approval of the payment~~
7 ~~methodologies required under Section 5A-12, Section 5A-12.1,~~
8 ~~or Section 5A-12.2, whichever is applicable for that fiscal~~
9 ~~year, and the waiver granted under 42 CFR 433.68, all~~
10 ~~installments otherwise due under Section 5A-2 prior to the date~~
11 ~~of notification shall be due and payable to the Department upon~~
12 ~~written direction from the Department and issuance by the~~
13 ~~Comptroller of the payments required under Section 5A-12.1 or~~
14 ~~Section 5A-12.2, whichever is applicable for that fiscal year.~~

15 (a-5) The Illinois Department may, for the purpose of
16 maximizing federal revenue, accelerate the schedule upon which
17 assessment installments are due and payable by hospitals with a
18 payment ratio greater than or equal to one. Such acceleration
19 of due dates for payment of the assessment may be made only in
20 conjunction with a corresponding acceleration in access
21 payments identified in Section 5A-12.2 to the same hospitals.
22 For the purposes of this subsection (a-5), a hospital's payment
23 ratio is defined as the quotient obtained by dividing the total
24 payments for the State fiscal year, as authorized under Section
25 5A-12.2, by the total assessment for the State fiscal year
26 imposed under Section 5A-2.

1 (b) The Illinois Department is authorized to establish
2 delayed payment schedules for hospital providers that are
3 unable to make installment payments when due under this Section
4 due to financial difficulties, as determined by the Illinois
5 Department.

6 (c) If a hospital provider fails to pay the full amount of
7 an installment when due (including any extensions granted under
8 subsection (b)), there shall, unless waived by the Illinois
9 Department for reasonable cause, be added to the assessment
10 imposed by Section 5A-2 a penalty assessment equal to the
11 lesser of (i) 5% of the amount of the installment not paid on
12 or before the due date plus 5% of the portion thereof remaining
13 unpaid on the last day of each 30-day period thereafter or (ii)
14 100% of the installment amount not paid on or before the due
15 date. For purposes of this subsection, payments will be
16 credited first to unpaid installment amounts (rather than to
17 penalty or interest), beginning with the most delinquent
18 installments.

19 (d) Any assessment amount that is due and payable to the
20 Illinois Department more frequently than once per calendar
21 quarter shall be remitted to the Illinois Department by the
22 hospital provider by means of electronic funds transfer. The
23 Illinois Department may provide for remittance by other means
24 if (i) the amount due is less than \$10,000 or (ii) electronic
25 funds transfer is unavailable for this purpose.

26 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;

1 96-821, eff. 11-20-09.)

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

3 Sec. 5A-5. Notice; penalty; maintenance of records.

4 (a) The Illinois Department ~~of Healthcare and Family~~
5 ~~Services~~ shall send a notice of assessment to every hospital
6 provider subject to assessment under this Article. The notice
7 of assessment shall notify the hospital of its assessment and
8 shall be sent after receipt by the Department of notification
9 from the Centers for Medicare and Medicaid Services of the U.S.
10 Department of Health and Human Services that the payment
11 methodologies required under this Article ~~Section 5A-12,~~
12 ~~Section 5A-12.1, or Section 5A-12.2, whichever is applicable~~
13 ~~for that fiscal year,~~ and, if necessary, the waiver granted
14 under 42 CFR 433.68 have been approved. The notice shall be on
15 a form prepared by the Illinois Department and shall state the
16 following:

17 (1) The name of the hospital provider.

18 (2) The address of the hospital provider's principal
19 place of business from which the provider engages in the
20 occupation of hospital provider in this State, and the name
21 and address of each hospital operated, conducted, or
22 maintained by the provider in this State.

23 (3) The occupied bed days, occupied bed days less
24 Medicare days, or adjusted gross hospital revenue of the
25 hospital provider (whichever is applicable), the amount of

1 assessment imposed under Section 5A-2 for the State fiscal
2 year for which the notice is sent, and the amount of each
3 installment to be paid during the State fiscal year.

4 (4) (Blank).

5 (5) Other reasonable information as determined by the
6 Illinois Department.

7 (b) If a hospital provider conducts, operates, or maintains
8 more than one hospital licensed by the Illinois Department of
9 Public Health, the provider shall pay the assessment for each
10 hospital separately.

11 (c) Notwithstanding any other provision in this Article, in
12 the case of a person who ceases to conduct, operate, or
13 maintain a hospital in respect of which the person is subject
14 to assessment under this Article as a hospital provider, the
15 assessment for the State fiscal year in which the cessation
16 occurs shall be adjusted by multiplying the assessment computed
17 under Section 5A-2 by a fraction, the numerator of which is the
18 number of days in the year during which the provider conducts,
19 operates, or maintains the hospital and the denominator of
20 which is 365. Immediately upon ceasing to conduct, operate, or
21 maintain a hospital, the person shall pay the assessment for
22 the year as so adjusted (to the extent not previously paid).

23 (d) Notwithstanding any other provision in this Article, a
24 provider who commences conducting, operating, or maintaining a
25 hospital, upon notice by the Illinois Department, shall pay the
26 assessment computed under Section 5A-2 and subsection (e) in

1 installments on the due dates stated in the notice and on the
2 regular installment due dates for the State fiscal year
3 occurring after the due dates of the initial notice.

4 ~~(e) Notwithstanding any other provision in this Article,~~
5 ~~for State fiscal years 2004 and 2005, in the case of a hospital~~
6 ~~provider that did not conduct, operate, or maintain a hospital~~
7 ~~throughout calendar year 2001, the assessment for that State~~
8 ~~fiscal year shall be computed on the basis of hypothetical~~
9 ~~occupied bed days for the full calendar year as determined by~~
10 ~~the Illinois Department. Notwithstanding any other provision~~
11 ~~in this Article, for State fiscal years 2006 through 2008, in~~
12 ~~the case of a hospital provider that did not conduct, operate,~~
13 ~~or maintain a hospital in 2003, the assessment for that State~~
14 ~~fiscal year shall be computed on the basis of hypothetical~~
15 ~~adjusted gross hospital revenue for the hospital's first full~~
16 ~~fiscal year as determined by the Illinois Department (which may~~
17 ~~be based on annualization of the provider's actual revenues for~~
18 ~~a portion of the year, or revenues of a comparable hospital for~~
19 ~~the year, including revenues realized by a prior provider of~~
20 ~~the same hospital during the year).~~ Notwithstanding any other
21 provision in this Article, for State fiscal years 2009 through
22 2015 ~~2014~~, in the case of a hospital provider that did not
23 conduct, operate, or maintain a hospital in 2005, the
24 assessment for that State fiscal year shall be computed on the
25 basis of hypothetical occupied bed days for the full calendar
26 year as determined by the Illinois Department.

1 (f) Every hospital provider subject to assessment under
2 this Article shall keep sufficient records to permit the
3 determination of adjusted gross hospital revenue for the
4 hospital's fiscal year. All such records shall be kept in the
5 English language and shall, at all times during regular
6 business hours of the day, be subject to inspection by the
7 Illinois Department or its duly authorized agents and
8 employees.

9 (g) The Illinois Department may, by rule, provide a
10 hospital provider a reasonable opportunity to request a
11 clarification or correction of any clerical or computational
12 errors contained in the calculation of its assessment, but such
13 corrections shall not extend to updating the cost report
14 information used to calculate the assessment.

15 (h) (Blank).

16 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
17 96-1530, eff. 2-16-11.)

18 (305 ILCS 5/5A-6) (from Ch. 23, par. 5A-6)

19 Sec. 5A-6. Disposition of proceeds. The Illinois
20 Department shall deposit ~~pay~~ all moneys received from hospital
21 providers under this Article into the Hospital Provider Fund.
22 Upon certification by the Illinois Department to the State
23 Comptroller of its intent to withhold payments from a provider
24 pursuant to ~~under~~ Section 5A-7(b), the State Comptroller shall
25 draw a warrant on the treasury or other fund held by the State

1 Treasurer, as appropriate. The warrant shall state the amount
2 for which the provider is entitled to a warrant, the amount of
3 the deduction, and the reason therefor and shall direct the
4 State Treasurer to pay the balance to the provider, all in
5 accordance with Section 10.05 of the State Comptroller Act. The
6 warrant also shall direct the State Treasurer to transfer the
7 amount of the deduction so ordered from the treasury or other
8 fund into the Hospital Provider Fund.

9 (Source: P.A. 87-861.)

10 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

11 Sec. 5A-8. Hospital Provider Fund.

12 (a) There is created in the State Treasury the Hospital
13 Provider Fund. Interest earned by the Fund shall be credited to
14 the Fund. The Fund shall not be used to replace any moneys
15 appropriated to the Medicaid program by the General Assembly.

16 (b) The Fund is created for the purpose of receiving moneys
17 in accordance with Section 5A-6 and disbursing moneys only for
18 the following purposes, notwithstanding any other provision of
19 law:

20 (1) For making payments to hospitals as required under
21 ~~Articles V, V-A, VI, and XIV of this Code, under the~~
22 Children's Health Insurance Program Act, under the
23 Covering ALL KIDS Health Insurance Act, and under the Long
24 Term Acute Care Hospital Quality Improvement Transfer
25 Program Act. ~~Senior Citizens and Disabled Persons Property~~

~~Tax Relief and Pharmaceutical Assistance Act.~~

(2) For the reimbursement of moneys collected by the Illinois Department from hospitals or hospital providers through error or mistake in performing the activities authorized under ~~this Article and Article V~~ of this Code.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing ~~the~~ activities under authorized by this Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, and the Long Term Acute Care Hospital Quality Improvement Transfer Program Act. ~~Article.~~

(4) For payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant.

(5) For making transfers, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making transfers to any other fund in the State treasury, but transfers made under this paragraph (6) shall not exceed the amount transferred previously from that other fund into the Hospital Provider Fund plus any interest that would have been earned by that fund on the monies that had been transferred.

1 (6.5) For making transfers to the Healthcare Provider
 2 Relief Fund, except that transfers made under this
 3 paragraph (6.5) shall not exceed \$60,000,000 in the
 4 aggregate.

5 (7) For making transfers not exceeding the following
 6 amounts, in each State fiscal year during which an
 7 assessment is imposed pursuant to Section 5A-2, to the
 8 following designated funds:

9 Health and Human Services Medicaid Trust

10 <u>Fund</u>	<u>\$20,000,000</u>
11 <u>Long-Term Care Provider Fund</u>	<u>\$30,000,000</u>
12 <u>General Revenue Fund</u>	<u>\$80,000,000.</u>

13 Transfers under this paragraph shall be made within 7 days
 14 after the payments have been received pursuant to the schedule
 15 of payments provided in subsection (a) of Section 5A-4. ~~For~~
 16 ~~State fiscal years 2004 and 2005 for making transfers to the~~
 17 ~~Health and Human Services Medicaid Trust Fund, including 20% of~~
 18 ~~the moneys received from hospital providers under Section 5A-4~~
 19 ~~and transferred into the Hospital Provider Fund under Section~~
 20 ~~5A-6. For State fiscal year 2006 for making transfers to the~~
 21 ~~Health and Human Services Medicaid Trust Fund of up to~~
 22 ~~\$130,000,000 per year of the moneys received from hospital~~
 23 ~~providers under Section 5A-4 and transferred into the Hospital~~
 24 ~~Provider Fund under Section 5A-6. Transfers under this~~
 25 ~~paragraph shall be made within 7 days after the payments have~~
 26 ~~been received pursuant to the schedule of payments provided in~~

1 ~~subsection (a) of Section 5A-4.~~

2 (7.5) (Blank). ~~For State fiscal year 2007 for making~~
3 ~~transfers of the moneys received from hospital providers~~
4 ~~under Section 5A-4 and transferred into the Hospital~~
5 ~~Provider Fund under Section 5A-6 to the designated funds~~
6 ~~not exceeding the following amounts in that State fiscal~~
7 ~~year:~~

8	Health and Human Services	
9	Medicaid Trust Fund	\$20,000,000
10	Long Term Care Provider Fund	-\$30,000,000
11	General Revenue Fund	-\$80,000,000.

12 ~~Transfers under this paragraph shall be made within 7~~
13 ~~days after the payments have been received pursuant to the~~
14 ~~schedule of payments provided in subsection (a) of Section~~
15 ~~5A-4.~~

16 (7.8) (Blank). ~~For State fiscal year 2008, for making~~
17 ~~transfers of the moneys received from hospital providers~~
18 ~~under Section 5A-4 and transferred into the Hospital~~
19 ~~Provider Fund under Section 5A-6 to the designated funds~~
20 ~~not exceeding the following amounts in that State fiscal~~
21 ~~year:~~

22	Health and Human Services	
23	Medicaid Trust Fund	\$40,000,000
24	Long Term Care Provider Fund	\$60,000,000
25	General Revenue Fund	\$160,000,000.

26 ~~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.~~

~~(7.9) (Blank). For State fiscal years 2009 through 2014, 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~~

~~Medicaid Trust Fund \$20,000,000~~

~~Long Term Care Provider Fund \$30,000,000~~

~~General Revenue Fund \$80,000,000.~~

~~Except as provided under this paragraph, transfers under this paragraph shall be made within 7 business days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4. For State fiscal year 2009, transfers to the General Revenue Fund under this paragraph shall be made on or before June 30, 2009, as sufficient funds become available in the Hospital Provider Fund to both make the transfers and continue hospital payments.~~

(8) For making refunds to hospital providers pursuant to Section 5A-10.

Disbursements from the Fund, other than transfers authorized under paragraphs (5) and (6) of this subsection,

1 shall be by warrants drawn by the State Comptroller upon
2 receipt of vouchers duly executed and certified by the Illinois
3 Department.

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

5 (1) All moneys collected or received by the Illinois
6 Department from the hospital provider assessment imposed
7 by this Article.

8 (2) All federal matching funds received by the Illinois
9 Department as a result of expenditures made by the Illinois
10 Department that are attributable to moneys deposited in the
11 Fund.

12 (3) Any interest or penalty levied in conjunction with
13 the administration of this Article.

14 (4) Moneys transferred from another fund in the State
15 treasury.

16 (5) All other moneys received for the Fund from any
17 other source, including interest earned thereon.

18 (d) (Blank).

19 (Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3,
20 eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09;
21 96-1530, eff. 2-16-11.)

22 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

23 Sec. 5A-10. Applicability.

24 (a) The assessment imposed by Section 5A-2 shall ~~not take~~
25 ~~effect or shall~~ cease to be imposed and the Department's

1 obligation to make payments shall immediately cease, and any
2 moneys remaining in the Fund shall be refunded to hospital
3 providers in proportion to the amounts paid by them, if:

4 (1) The payments to hospitals required under this
5 Article are not eligible for federal matching funds under
6 Title XIX or XXI of the Social Security Act ~~The sum of the~~
7 ~~appropriations for State fiscal years 2004 and 2005 from~~
8 ~~the General Revenue Fund for hospital payments under the~~
9 ~~medical assistance program is less than \$4,500,000,000 or~~
10 ~~the appropriation for each of State fiscal years 2006, 2007~~
11 ~~and 2008 from the General Revenue Fund for hospital~~
12 ~~payments under the medical assistance program is less than~~
13 ~~\$2,500,000,000 increased annually to reflect any increase~~
14 ~~in the number of recipients, or the annual appropriation~~
15 ~~for State fiscal years 2009, 2010, 2011, 2013, and 2014,~~
16 ~~from the General Revenue Fund combined with the Hospital~~
17 ~~Provider Fund as authorized in Section 5A-8 for hospital~~
18 ~~payments under the medical assistance program, is less than~~
19 ~~the amount appropriated for State fiscal year 2009,~~
20 ~~adjusted annually to reflect any change in the number of~~
21 ~~recipients, excluding State fiscal year 2009 supplemental~~
22 ~~appropriations made necessary by the enactment of the~~
23 ~~American Recovery and Reinvestment Act of 2009; or~~

24 ~~(2) For State fiscal years prior to State fiscal year~~
25 ~~2009, the Department of Healthcare and Family Services~~
26 ~~(formerly Department of Public Aid) makes changes in its~~

1 ~~rules that reduce the hospital inpatient or outpatient~~
2 ~~payment rates, including adjustment payment rates, in~~
3 ~~effect on October 1, 2004, except for hospitals described~~
4 ~~in subsection (b) of Section 5A-3 and except for changes in~~
5 ~~the methodology for calculating outlier payments to~~
6 ~~hospitals for exceptionally costly stays, so long as those~~
7 ~~changes do not reduce aggregate expenditures below the~~
8 ~~amount expended in State fiscal year 2005 for such~~
9 ~~services; or~~

10 (2) ~~(2.1)~~ For State fiscal years 2009 through 2014 and
11 July 1, 2014 through December 31, 2014, the Department of
12 Healthcare and Family Services adopts any administrative
13 rule change to reduce payment rates or alters any payment
14 methodology that reduces any payment rates made to
15 operating hospitals under the approved Title XIX or Title
16 XXI State plan in effect January 1, 2008 except for:

17 (A) any changes for hospitals described in
18 subsection (b) of Section 5A-3; or

19 (B) any rates for payments made under this Article
20 V-A; or

21 (C) any changes proposed in State plan amendment
22 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
23 08-07; ~~or~~

24 (D) in relation to any admissions on or after
25 January 1, 2011, a modification in the methodology for
26 calculating outlier payments to hospitals for

1 exceptionally costly stays, for hospitals reimbursed
2 under the diagnosis-related grouping methodology in
3 effect on January 1, 2011; provided that the Department
4 shall be limited to one such modification during the
5 36-month period after the effective date of this
6 amendatory Act of the 96th General Assembly; or

7 (E) any changes affecting hospitals authorized by
8 this amendatory Act of the 97th General Assembly.

9 ~~(3) The payments to hospitals required under Section~~
10 ~~5A 12 or Section 5A 12.2 are changed or are not eligible~~
11 ~~for federal matching funds under Title XIX or XXI of the~~
12 ~~Social Security Act.~~

13 (b) The assessment imposed by Section 5A-2 shall not take
14 effect or shall cease to be imposed and the Department's
15 obligation to make payments shall immediately cease if the
16 assessment is determined to be an impermissible tax under Title
17 XIX of the Social Security Act. Moneys in the Hospital Provider
18 Fund derived from assessments imposed prior thereto shall be
19 disbursed in accordance with Section 5A-8 to the extent federal
20 financial participation is not reduced due to the
21 impermissibility of the assessments, and any remaining moneys
22 shall be refunded to hospital providers in proportion to the
23 amounts paid by them.

24 (Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72,
25 eff. 7-1-11; 97-74, eff. 6-30-11.)

1 (305 ILCS 5/5A-12.2)

2 (Section scheduled to be repealed on July 1, 2014)

3 Sec. 5A-12.2. Hospital access payments on or after July 1,
4 2008.

5 (a) To preserve and improve access to hospital services,
6 for hospital services rendered on or after July 1, 2008, the
7 Illinois Department shall, except for hospitals described in
8 subsection (b) of Section 5A-3, make payments to hospitals as
9 set forth in this Section. These payments shall be paid in 12
10 equal installments on or before the seventh State business day
11 of each month, except that no payment shall be due within 100
12 days after the later of the date of notification of federal
13 approval of the payment methodologies required under this
14 Section or any waiver required under 42 CFR 433.68, at which
15 time the sum of amounts required under this Section prior to
16 the date of notification is due and payable. Payments under
17 this Section are not due and payable, however, until (i) the
18 methodologies described in this Section are approved by the
19 federal government in an appropriate State Plan amendment and
20 (ii) the assessment imposed under this Article is determined to
21 be a permissible tax under Title XIX of the Social Security
22 Act.

23 (a-5) The Illinois Department may, when practicable,
24 accelerate the schedule upon which payments authorized under
25 this Section are made.

26 (b) Across-the-board inpatient adjustment.

1 (1) In addition to rates paid for inpatient hospital
2 services, the Department shall pay to each Illinois general
3 acute care hospital an amount equal to 40% of the total
4 base inpatient payments paid to the hospital for services
5 provided in State fiscal year 2005.

6 (2) In addition to rates paid for inpatient hospital
7 services, the Department shall pay to each freestanding
8 Illinois specialty care hospital as defined in 89 Ill. Adm.
9 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
10 the total base inpatient payments paid to the hospital for
11 services provided in State fiscal year 2005.

12 (3) In addition to rates paid for inpatient hospital
13 services, the Department shall pay to each freestanding
14 Illinois rehabilitation or psychiatric hospital an amount
15 equal to \$1,000 per Medicaid inpatient day multiplied by
16 the increase in the hospital's Medicaid inpatient
17 utilization ratio (determined using the positive
18 percentage change from the rate year 2005 Medicaid
19 inpatient utilization ratio to the rate year 2007 Medicaid
20 inpatient utilization ratio, as calculated by the
21 Department for the disproportionate share determination).

22 (4) In addition to rates paid for inpatient hospital
23 services, the Department shall pay to each Illinois
24 children's hospital an amount equal to 20% of the total
25 base inpatient payments paid to the hospital for services
26 provided in State fiscal year 2005 and an additional amount

1 equal to 20% of the base inpatient payments paid to the
2 hospital for psychiatric services provided in State fiscal
3 year 2005.

4 (5) In addition to rates paid for inpatient hospital
5 services, the Department shall pay to each Illinois
6 hospital eligible for a pediatric inpatient adjustment
7 payment under 89 Ill. Adm. Code 148.298, as in effect for
8 State fiscal year 2007, a supplemental pediatric inpatient
9 adjustment payment equal to:

10 (i) For freestanding children's hospitals as
11 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
12 multiplied by the hospital's pediatric inpatient
13 adjustment payment required under 89 Ill. Adm. Code
14 148.298, as in effect for State fiscal year 2008.

15 (ii) For hospitals other than freestanding
16 children's hospitals as defined in 89 Ill. Adm. Code
17 149.50(c)(3)(B), 1.0 multiplied by the hospital's
18 pediatric inpatient adjustment payment required under
19 89 Ill. Adm. Code 148.298, as in effect for State
20 fiscal year 2008.

21 (c) Outpatient adjustment.

22 (1) In addition to the rates paid for outpatient
23 hospital services, the Department shall pay each Illinois
24 hospital an amount equal to 2.2 multiplied by the
25 hospital's ambulatory procedure listing payments for
26 categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code

1 148.140(b), for State fiscal year 2005.

2 (2) In addition to the rates paid for outpatient
3 hospital services, the Department shall pay each Illinois
4 freestanding psychiatric hospital an amount equal to 3.25
5 multiplied by the hospital's ambulatory procedure listing
6 payments for category 5b, as defined in 89 Ill. Adm. Code
7 148.140(b)(1)(E), for State fiscal year 2005.

8 (d) Medicaid high volume adjustment. In addition to rates
9 paid for inpatient hospital services, the Department shall pay
10 to each Illinois general acute care hospital that provided more
11 than 20,500 Medicaid inpatient days of care in State fiscal
12 year 2005 amounts as follows:

13 (1) For hospitals with a case mix index equal to or
14 greater than the 85th percentile of hospital case mix
15 indices, \$350 for each Medicaid inpatient day of care
16 provided during that period; and

17 (2) For hospitals with a case mix index less than the
18 85th percentile of hospital case mix indices, \$100 for each
19 Medicaid inpatient day of care provided during that period.

20 (e) Capital adjustment. In addition to rates paid for
21 inpatient hospital services, the Department shall pay an
22 additional payment to each Illinois general acute care hospital
23 that has a Medicaid inpatient utilization rate of at least 10%
24 (as calculated by the Department for the rate year 2007
25 disproportionate share determination) amounts as follows:

26 (1) For each Illinois general acute care hospital that

1 has a Medicaid inpatient utilization rate of at least 10%
2 and less than 36.94% and whose capital cost is less than
3 the 60th percentile of the capital costs of all Illinois
4 hospitals, the amount of such payment shall equal the
5 hospital's Medicaid inpatient days multiplied by the
6 difference between the capital costs at the 60th percentile
7 of the capital costs of all Illinois hospitals and the
8 hospital's capital costs.

9 (2) For each Illinois general acute care hospital that
10 has a Medicaid inpatient utilization rate of at least
11 36.94% and whose capital cost is less than the 75th
12 percentile of the capital costs of all Illinois hospitals,
13 the amount of such payment shall equal the hospital's
14 Medicaid inpatient days multiplied by the difference
15 between the capital costs at the 75th percentile of the
16 capital costs of all Illinois hospitals and the hospital's
17 capital costs.

18 (f) Obstetrical care adjustment.

19 (1) In addition to rates paid for inpatient hospital
20 services, the Department shall pay \$1,500 for each Medicaid
21 obstetrical day of care provided in State fiscal year 2005
22 by each Illinois rural hospital that had a Medicaid
23 obstetrical percentage (Medicaid obstetrical days divided
24 by Medicaid inpatient days) greater than 15% for State
25 fiscal year 2005.

26 (2) In addition to rates paid for inpatient hospital

1 services, the Department shall pay \$1,350 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 III perinatal center as of December 31,
5 2006, and that had a case mix index equal to or greater
6 than the 45th percentile of the case mix indices for all
7 level III perinatal centers.

8 (3) In addition to rates paid for inpatient hospital
9 services, the Department shall pay \$900 for each Medicaid
10 obstetrical day of care provided in State fiscal year 2005
11 by each Illinois general acute care hospital that was
12 designated a level II or II+ perinatal center as of
13 December 31, 2006, and that had a case mix index equal to
14 or greater than the 35th percentile of the case mix indices
15 for all level II and II+ perinatal centers.

16 (g) Trauma adjustment.

17 (1) In addition to rates paid for inpatient hospital
18 services, the Department shall pay each Illinois general
19 acute care hospital designated as a trauma center as of
20 July 1, 2007, a payment equal to 3.75 multiplied by the
21 hospital's State fiscal year 2005 Medicaid capital
22 payments.

23 (2) In addition to rates paid for inpatient hospital
24 services, the Department shall pay \$400 for each Medicaid
25 acute inpatient day of care provided in State fiscal year
26 2005 by each Illinois general acute care hospital that was

1 designated a level II trauma center, as defined in 89 Ill.
2 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,
3 2007.

4 (3) In addition to rates paid for inpatient hospital
5 services, the Department shall pay \$235 for each Illinois
6 Medicaid acute inpatient day of care provided in State
7 fiscal year 2005 by each level I pediatric trauma center
8 located outside of Illinois that had more than 8,000
9 Illinois Medicaid inpatient days in State fiscal year 2005.

10 (h) Supplemental tertiary care adjustment. In addition to
11 rates paid for inpatient services, the Department shall pay to
12 each Illinois hospital eligible for tertiary care adjustment
13 payments under 89 Ill. Adm. Code 148.296, as in effect for
14 State fiscal year 2007, a supplemental tertiary care adjustment
15 payment equal to the tertiary care adjustment payment required
16 under 89 Ill. Adm. Code 148.296, as in effect for State fiscal
17 year 2007.

18 (i) Crossover adjustment. In addition to rates paid for
19 inpatient services, the Department shall pay each Illinois
20 general acute care hospital that had a ratio of crossover days
21 to total inpatient days for medical assistance programs
22 administered by the Department (utilizing information from
23 2005 paid claims) greater than 50%, and a case mix index
24 greater than the 65th percentile of case mix indices for all
25 Illinois hospitals, a rate of \$1,125 for each Medicaid
26 inpatient day including crossover days.

1 (j) Magnet hospital adjustment. In addition to rates paid
2 for inpatient hospital services, the Department shall pay to
3 each Illinois general acute care hospital and each Illinois
4 freestanding children's hospital that, as of February 1, 2008,
5 was recognized as a Magnet hospital by the American Nurses
6 Credentialing Center and that had a case mix index greater than
7 the 75th percentile of case mix indices for all Illinois
8 hospitals amounts as follows:

9 (1) For hospitals located in a county whose eligibility
10 growth factor is greater than the mean, \$450 multiplied by
11 the eligibility growth factor for the county in which the
12 hospital is located for each Medicaid inpatient day of care
13 provided by the hospital during State fiscal year 2005.

14 (2) For hospitals located in a county whose eligibility
15 growth factor is less than or equal to the mean, \$225
16 multiplied by the eligibility growth factor for the county
17 in which the hospital is located for each Medicaid
18 inpatient day of care provided by the hospital during State
19 fiscal year 2005.

20 For purposes of this subsection, "eligibility growth
21 factor" means the percentage by which the number of Medicaid
22 recipients in the county increased from State fiscal year 1998
23 to State fiscal year 2005.

24 (k) For purposes of this Section, a hospital that is
25 enrolled to provide Medicaid services during State fiscal year
26 2005 shall have its utilization and associated reimbursements

1 annualized prior to the payment calculations being performed
2 under this Section.

3 (l) For purposes of this Section, the terms "Medicaid
4 days", "ambulatory procedure listing services", and
5 "ambulatory procedure listing payments" do not include any
6 days, charges, or services for which Medicare or a managed care
7 organization reimbursed on a capitated basis was liable for
8 payment, except where explicitly stated otherwise in this
9 Section.

10 (m) For purposes of this Section, in determining the
11 percentile ranking of an Illinois hospital's case mix index or
12 capital costs, hospitals described in subsection (b) of Section
13 5A-3 shall be excluded from the ranking.

14 (n) Definitions. Unless the context requires otherwise or
15 unless provided otherwise in this Section, the terms used in
16 this Section for qualifying criteria and payment calculations
17 shall have the same meanings as those terms have been given in
18 the Illinois Department's administrative rules as in effect on
19 March 1, 2008. Other terms shall be defined by the Illinois
20 Department by rule.

21 As used in this Section, unless the context requires
22 otherwise:

23 "Base inpatient payments" means, for a given hospital, the
24 sum of base payments for inpatient services made on a per diem
25 or per admission (DRG) basis, excluding those portions of per
26 admission payments that are classified as capital payments.

1 Disproportionate share hospital adjustment payments, Medicaid
2 Percentage Adjustments, Medicaid High Volume Adjustments, and
3 outlier payments, as defined by rule by the Department as of
4 January 1, 2008, are not base payments.

5 "Capital costs" means, for a given hospital, the total
6 capital costs determined using the most recent 2005 Medicare
7 cost report as contained in the Healthcare Cost Report
8 Information System file, for the quarter ending on December 31,
9 2006, divided by the total inpatient days from the same cost
10 report to calculate a capital cost per day. The resulting
11 capital cost per day is inflated to the midpoint of State
12 fiscal year 2009 utilizing the national hospital market price
13 proxies (DRI) hospital cost index. If a hospital's 2005
14 Medicare cost report is not contained in the Healthcare Cost
15 Report Information System, the Department may obtain the data
16 necessary to compute the hospital's capital costs from any
17 source available, including, but not limited to, records
18 maintained by the hospital provider, which may be inspected at
19 all times during business hours of the day by the Illinois
20 Department or its duly authorized agents and employees.

21 "Case mix index" means, for a given hospital, the sum of
22 the DRG relative weighting factors in effect on January 1,
23 2005, for all general acute care admissions for State fiscal
24 year 2005, excluding Medicare crossover admissions and
25 transplant admissions reimbursed under 89 Ill. Adm. Code
26 148.82, divided by the total number of general acute care

1 admissions for State fiscal year 2005, excluding Medicare
2 crossover admissions and transplant admissions reimbursed
3 under 89 Ill. Adm. Code 148.82.

4 "Medicaid inpatient day" means, for a given hospital, the
5 sum of days of inpatient hospital days provided to recipients
6 of medical assistance under Title XIX of the federal Social
7 Security Act, excluding days for individuals eligible for
8 Medicare under Title XVIII of that Act (Medicaid/Medicare
9 crossover days), as tabulated from the Department's paid claims
10 data for admissions occurring during State fiscal year 2005
11 that was adjudicated by the Department through March 23, 2007.

12 "Medicaid obstetrical day" means, for a given hospital, the
13 sum of days of inpatient hospital days grouped by the
14 Department to DRGs of 370 through 375 provided to recipients of
15 medical assistance under Title XIX of the federal Social
16 Security Act, excluding days for individuals eligible for
17 Medicare under Title XVIII of that Act (Medicaid/Medicare
18 crossover days), as tabulated from the Department's paid claims
19 data for admissions occurring during State fiscal year 2005
20 that was adjudicated by the Department through March 23, 2007.

21 "Outpatient ambulatory procedure listing payments" means,
22 for a given hospital, the sum of payments for ambulatory
23 procedure listing services, as described in 89 Ill. Adm. Code
24 148.140(b), provided to recipients of medical assistance under
25 Title XIX of the federal Social Security Act, excluding
26 payments for individuals eligible for Medicare under Title

1 XVIII of the Act (Medicaid/Medicare crossover days), as
2 tabulated from the Department's paid claims data for services
3 occurring in State fiscal year 2005 that were adjudicated by
4 the Department through March 23, 2007.

5 (o) The Department may adjust payments made under this
6 Section 5A-12.2 ~~12.2~~ to comply with federal law or regulations
7 regarding hospital-specific payment limitations on
8 government-owned or government-operated hospitals.

9 (p) Notwithstanding any of the other provisions of this
10 Section, the Department is authorized to adopt rules that
11 change the hospital access improvement payments specified in
12 this Section, but only to the extent necessary to conform to
13 any federally approved amendment to the Title XIX State plan.
14 Any such rules shall be adopted by the Department as authorized
15 by Section 5-50 of the Illinois Administrative Procedure Act.
16 Notwithstanding any other provision of law, any changes
17 implemented as a result of this subsection (p) shall be given
18 retroactive effect so that they shall be deemed to have taken
19 effect as of the effective date of this Section.

20 (q) (Blank). ~~For State fiscal years 2012 and 2013, the~~
21 ~~Department may make recommendations to the General Assembly~~
22 ~~regarding the use of more recent data for purposes of~~
23 ~~calculating the assessment authorized under Section 5A-2 and~~
24 ~~the payments authorized under this Section 5A-12.2.~~

25 (r) On and after July 1, 2012, the Department shall reduce
26 any rate of reimbursement for services or other payments or

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

4 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09.)

5 (305 ILCS 5/5A-14)

6 Sec. 5A-14. Repeal of assessments and disbursements.

7 (a) Section 5A-2 is repealed on January 1, 2015 ~~July 1,~~
8 ~~2014.~~

9 (b) Section 5A-12 is repealed on July 1, 2005.

10 (c) Section 5A-12.1 is repealed on July 1, 2008.

11 (d) Section 5A-12.2 is repealed on January 1, 2015 ~~July 1,~~
12 ~~2014.~~

13 (e) Section 5A-12.3 is repealed on July 1, 2011.

14 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09;
15 96-1530, eff. 2-16-11.)

16 (305 ILCS 5/5A-15 new)

17 Sec. 5A-15. Protection of federal revenue.

18 (a) If the federal Centers for Medicare and Medicaid
19 Services finds that any federal upper payment limit applicable
20 to the payments under this Article is exceeded then:

21 (1) the payments under this Article that exceed the
22 applicable federal upper payment limit shall be reduced
23 uniformly to the extent necessary to comply with the
24 applicable federal upper payment limit; and

1 (2) any assessment rate imposed under this Article
2 shall be reduced such that the aggregate assessment is
3 reduced by the same percentage reduction applied in
4 paragraph (1); and

5 (3) any transfers from the Hospital Provider Fund under
6 Section 5A-8 shall be reduced by the same percentage
7 reduction applied in paragraph (1).

8 (b) Any payment reductions made under the authority granted
9 in this Section are exempt from the requirements and actions
10 under Section 5A-10.

11 (305 ILCS 5/6-11) (from Ch. 23, par. 6-11)

12 Sec. 6-11. ~~State funded~~ General Assistance.

13 (a) Effective July 1, 1992, all State funded General
14 Assistance and related medical benefits shall be governed by
15 this Section, provided that, notwithstanding any other
16 provisions of this Code to the contrary, on and after July 1,
17 2012, the State shall not fund the programs outlined in this
18 Section. Other parts of this Code or other laws related to
19 General Assistance shall remain in effect to the extent they do
20 not conflict with the provisions of this Section. If any other
21 part of this Code or other laws of this State conflict with the
22 provisions of this Section, the provisions of this Section
23 shall control.

24 (b) ~~State funded~~ General Assistance may ~~shall~~ consist of 2
25 separate programs. One program shall be for adults with no

1 children and shall be known as ~~State~~ Transitional Assistance.
2 The other program may ~~shall~~ be for families with children and
3 for pregnant women and shall be known as ~~State~~ Family and
4 Children Assistance.

5 (c) (1) To be eligible for ~~State~~ Transitional Assistance on
6 or after July 1, 1992, an individual must be ineligible for
7 assistance under any other Article of this Code, must be
8 determined chronically needy, and must be one of the following:

9 (A) age 18 or over or

10 (B) married and living with a spouse, regardless of
11 age.

12 (2) The ~~Illinois Department or the~~ local governmental unit
13 shall determine whether individuals are chronically needy as
14 follows:

15 (A) Individuals who have applied for Supplemental
16 Security Income (SSI) and are awaiting a decision on
17 eligibility for SSI who are determined disabled by the
18 Illinois Department using the SSI standard shall be
19 considered chronically needy, except that individuals
20 whose disability is based solely on substance addictions
21 (drug abuse and alcoholism) and whose disability would
22 cease were their addictions to end shall be eligible only
23 for medical assistance and shall not be eligible for cash
24 assistance under the ~~State~~ Transitional Assistance
25 program.

26 (B) (Blank). ~~If an individual has been denied SSI due~~

1 ~~to a finding of "not disabled" (either at the~~
2 ~~Administrative Law Judge level or above, or at a lower~~
3 ~~level if that determination was not appealed), the Illinois~~
4 ~~Department shall adopt that finding and the individual~~
5 ~~shall not be eligible for State Transitional Assistance or~~
6 ~~any related medical benefits. Such an individual may not be~~
7 ~~determined disabled by the Illinois Department for a period~~
8 ~~of 12 months, unless the individual shows that there has~~
9 ~~been a substantial change in his or her medical condition~~
10 ~~or that there has been a substantial change in other~~
11 ~~factors, such as age or work experience, that might change~~
12 ~~the determination of disability.~~

13 (C) The unit of local government ~~Illinois Department,~~
14 ~~by rule,~~ may specify other categories of individuals as
15 chronically needy; nothing in this Section, however, shall
16 be deemed to require the inclusion of any specific category
17 other than as specified in paragraph ~~paragraphs~~ (A) and
18 ~~(B).~~

19 (3) For individuals in ~~State~~ Transitional Assistance,
20 medical assistance may ~~shall~~ be provided by the unit of local
21 government in an amount and nature determined by the unit of
22 local government. ~~Nothing Department of Healthcare and Family~~
23 ~~Services by rule. The amount and nature of medical assistance~~
24 ~~provided need not be the same as that provided under paragraph~~
25 ~~(4) of subsection (d) of this Section, and nothing in this~~
26 paragraph (3) shall be construed to require the coverage of any

1 particular medical service. In addition, the amount and nature
2 of medical assistance provided may be different for different
3 categories of individuals determined chronically needy.

4 (4) (Blank). ~~The Illinois Department shall determine, by~~
5 ~~rule, those assistance recipients under Article VI who shall be~~
6 ~~subject to employment, training, or education programs~~
7 ~~including Earnfare, the content of those programs, and the~~
8 ~~penalties for failure to cooperate in those programs.~~

9 (5) (Blank). ~~The Illinois Department shall, by rule,~~
10 ~~establish further eligibility requirements, including but not~~
11 ~~limited to residence, need, and the level of payments.~~

12 (d) (1) To be eligible for ~~State~~ Family and Children
13 Assistance, a family unit must be ineligible for assistance
14 under any other Article of this Code and must contain a child
15 who is:

16 (A) under age 18 or

17 (B) age 18 and a full-time student in a secondary
18 school or the equivalent level of vocational or technical
19 training, and who may reasonably be expected to complete
20 the program before reaching age 19.

21 Those children shall be eligible for ~~State~~ Family and
22 Children Assistance.

23 (2) The natural or adoptive parents of the child living in
24 the same household may be eligible for ~~State~~ Family and
25 Children Assistance.

26 (3) A pregnant woman whose pregnancy has been verified

1 shall be eligible for income maintenance assistance under the
2 ~~State~~ Family and Children Assistance program.

3 (4) The amount and nature of medical assistance provided
4 under the ~~State~~ Family and Children Assistance program shall be
5 determined by the unit of local government ~~Department of~~
6 ~~Healthcare and Family Services by rule~~. The amount and nature
7 of medical assistance provided need not be the same as that
8 provided under paragraph (3) of subsection (c) of this Section,
9 and nothing in this paragraph (4) shall be construed to require
10 the coverage of any particular medical service.

11 (5) (Blank). ~~The Illinois Department shall, by rule,~~
12 ~~establish further eligibility requirements, including but not~~
13 ~~limited to residence, need, and the level of payments.~~

14 (e) A local governmental unit that chooses to participate
15 in a General Assistance program under this Section shall
16 provide funding in accordance with Section 12-21.13 of this
17 Act. Local governmental funds used to qualify for State funding
18 may only be expended for clients eligible for assistance under
19 this Section 6-11 and related administrative expenses.

20 (f) (Blank). ~~In order to qualify for State funding under~~
21 ~~this Section, a local governmental unit shall be subject to the~~
22 ~~supervision and the rules and regulations of the Illinois~~
23 ~~Department.~~

24 (g) (Blank). ~~Notwithstanding any other provision in this~~
25 ~~Code, the Illinois Department is authorized to reduce payment~~
26 ~~levels used to determine cash grants provided to recipients of~~

~~State Transitional Assistance at any time within a Fiscal Year in order to ensure that cash benefits for State Transitional Assistance do not exceed the amounts appropriated for those cash benefits. Changes in payment levels may be accomplished by emergency rule under Section 5-45 of the Illinois Administrative Procedure Act, except that the limitation on the number of emergency rules that may be adopted in a 24 month period shall not apply and the provisions of Sections 5-115 and 5-125 of the Illinois Administrative Procedure Act shall not apply. This provision shall also be applicable to any reduction in payment levels made upon implementation of this amendatory Act of 1995.~~

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

(305 ILCS 5/11-5.2 new)

Sec. 11-5.2. Income, Residency, and Identity Verification System.

(a) The Department shall ensure that its proposed integrated eligibility system shall include the computerized functions of income, residency, and identity eligibility verification to verify eligibility, eliminate duplication of medical assistance, and deter fraud. Until the integrated eligibility system is operational, the Department may enter into a contract with the vendor selected pursuant to Section 11-5.3 as necessary to obtain the electronic data matching described in this Section. This contract shall be exempt from

1 the Illinois Procurement Code pursuant to subsection (h) of
2 Section 1-10 of that Code.

3 (b) Prior to awarding medical assistance at application
4 under Article V of this Code, the Department shall, to the
5 extent such databases are available to the Department, conduct
6 data matches using the name, date of birth, address, and Social
7 Security Number of each applicant or recipient or responsible
8 relative of an applicant or recipient against the following:

9 (1) Income tax information.

10 (2) Employer reports of income and unemployment
11 insurance payment information maintained by the Department
12 of Employment Security.

13 (3) Earned and unearned income, citizenship and death,
14 and other relevant information maintained by the Social
15 Security Administration.

16 (4) Immigration status information maintained by the
17 United States Citizenship and Immigration Services.

18 (5) Wage reporting and similar information maintained
19 by states contiguous to this State.

20 (6) Employment information maintained by the
21 Department of Employment Security in its New Hire Directory
22 database.

23 (7) Employment information maintained by the United
24 States Department of Health and Human Services in its
25 National Directory of New Hires database.

26 (8) Veterans' benefits information maintained by the

1 United States Department of Health and Human Services, in
2 coordination with the Department of Health and Human
3 Services and the Department of Veterans' Affairs, in the
4 federal Public Assistance Reporting Information System
5 (PARIS) database.

6 (9) Residency information maintained by the Illinois
7 Secretary of State.

8 (10) A database which is substantially similar to or a
9 successor of a database described in this Section that
10 contains information relevant for verifying eligibility
11 for medical assistance.

12 (d) If a discrepancy results between information provided
13 by an applicant, recipient, or responsible relative and
14 information contained in one or more of the databases or
15 information tools listed under subsection (b) or (c) of this
16 Section or subsection (c) of Section 11-5.3 and that
17 discrepancy calls into question the accuracy of information
18 relevant to a condition of eligibility provided by the
19 applicant, recipient, or responsible relative, the Department
20 or its contractor shall review the applicant's or recipient's
21 case using the following procedures:

22 (1) If the information discovered under subsection (c)
23 of this Section or subsection (c) of Section 11-5.3 does
24 not result in the Department finding the applicant or
25 recipient ineligible for assistance under Article V of this
26 Code, the Department shall finalize the determination or

1 redetermination of eligibility.

2 (2) If the information discovered results in the
3 Department finding the applicant or recipient ineligible
4 for assistance, the Department shall provide notice as set
5 forth in Section 11-7 of this Article.

6 (3) If the information discovered is insufficient to
7 determine that the applicant or recipient is eligible or
8 ineligible, the Department shall provide written notice to
9 the applicant or recipient which shall describe in
10 sufficient detail the circumstances of the discrepancy,
11 the information or documentation required, the manner in
12 which the applicant or recipient may respond, and the
13 consequences of failing to take action. The applicant or
14 recipient shall have 10 business days to respond.

15 (4) If the applicant or recipient does not respond to
16 the notice, the Department shall deny assistance for
17 failure to cooperate, in which case the Department shall
18 provide notice as set forth in Section 11-7. Eligibility
19 for assistance shall not be established until the
20 discrepancy has been resolved.

21 (5) If an applicant or recipient responds to the
22 notice, the Department shall determine the effect of the
23 information or documentation provided on the applicant's
24 or recipient's case and shall take appropriate action.
25 Written notice of the Department's action shall be provided
26 as set forth in Section 11-7 of this Article.

1 (6) Suspected cases of fraud shall be referred to the
2 Department's Inspector General.

3 (e) The Department shall adopt any rules necessary to
4 implement this Section.

5 (305 ILCS 5/11-5.3 new)

6 Sec. 11-5.3. Procurement of vendor to verify eligibility
7 for assistance under Article V.

8 (a) No later than 60 days after the effective date of this
9 amendatory Act of the 97th General Assembly, the Chief
10 Procurement Officer for General Services, in consultation with
11 the Department of Healthcare and Family Services, shall conduct
12 and complete any procurement necessary to procure a vendor to
13 verify eligibility for assistance under Article V of this Code.
14 Such authority shall include procuring a vendor to assist the
15 Chief Procurement Officer in conducting the procurement. The
16 Chief Procurement Officer and the Department shall jointly
17 negotiate final contract terms with a vendor selected by the
18 Chief Procurement Officer. Within 30 days of selection of an
19 eligibility verification vendor, the Department of Healthcare
20 and Family Services shall enter into a contract with the
21 selected vendor. The Department of Healthcare and Family
22 Services and the Department of Human Services shall cooperate
23 with and provide any information requested by the Chief
24 Procurement Officer to conduct the procurement.

25 (b) Notwithstanding any other provision of law, any

1 procurement or contract necessary to comply with this Section
2 shall be exempt from: (i) the Illinois Procurement Code
3 pursuant to Section 1-10(h) of the Illinois Procurement Code,
4 except that bidders shall comply with the disclosure
5 requirement in Sections 50-10.5(a) through (d), 50-13, 50-35,
6 and 50-37 of the Illinois Procurement Code and a vendor awarded
7 a contract under this Section shall comply with Section 50-37
8 of the Illinois Procurement Code; (ii) any administrative rules
9 of this State pertaining to procurement or contract formation;
10 and (iii) any State or Department policies or procedures
11 pertaining to procurement, contract formation, contract award,
12 and Business Enterprise Program approval.

13 (c) Upon becoming operational, the contractor shall
14 conduct data matches using the name, date of birth, address,
15 and Social Security Number of each applicant and recipient
16 against public records to verify eligibility. The contractor,
17 upon preliminary determination that an enrollee is eligible or
18 ineligible, shall notify the Department. Within 20 business
19 days of such notification, the Department shall accept the
20 recommendation or reject it with a stated reason. The
21 Department shall retain final authority over eligibility
22 determinations. The contractor shall keep a record of all
23 preliminary determinations of ineligibility communicated to
24 the Department. Within 30 days of the end of each calendar
25 quarter, the Department and contractor shall file a joint
26 report on a quarterly basis to the Governor, the Speaker of the

1 House of Representatives, the Minority Leader of the House of
2 Representatives, the Senate President, and the Senate Minority
3 Leader. The report shall include, but shall not be limited to,
4 monthly recommendations of preliminary determinations of
5 eligibility or ineligibility communicated by the contractor,
6 the actions taken on those preliminary determinations by the
7 Department, and the stated reasons for those recommendations
8 that the Department rejected.

9 (d) An eligibility verification vendor contract shall be
10 awarded for an initial 2-year period with up to a maximum of 2
11 one-year renewal options. Nothing in this Section shall compel
12 the award of a contract to a vendor that fails to meet the
13 needs of the Department. A contract with a vendor to assist in
14 the procurement shall be awarded for a period of time not to
15 exceed 6 months.

16 (305 ILCS 5/11-13) (from Ch. 23, par. 11-13)

17 Sec. 11-13. Conditions For Receipt of Vendor Payments -
18 Limitation Period For Vendor Action - Penalty For Violation. A
19 vendor payment, as defined in Section 2-5 of Article II, shall
20 constitute payment in full for the goods or services covered
21 thereby. Acceptance of the payment by or in behalf of the
22 vendor shall bar him from obtaining, or attempting to obtain,
23 additional payment therefor from the recipient or any other
24 person. A vendor payment shall not, however, bar recovery of
25 the value of goods and services the obligation for which, under

1 the rules and regulations of the Illinois Department, is to be
2 met from the income and resources available to the recipient,
3 and in respect to which the vendor payment of the Illinois
4 Department or the local governmental unit represents
5 supplementation of such available income and resources.

6 Vendors seeking to enforce obligations of a governmental
7 unit or the Illinois Department for goods or services (1)
8 furnished to or in behalf of recipients and (2) subject to a
9 vendor payment as defined in Section 2-5, shall commence their
10 actions in the appropriate Circuit Court or the Court of
11 Claims, as the case may require, within one year next after the
12 cause of action accrued.

13 A cause of action accrues within the meaning of this
14 Section upon the following date:

15 (1) If the vendor can prove that he submitted a bill for
16 the service rendered to the Illinois Department or a
17 governmental unit within 180 days after ~~12 months of~~ the date
18 the service was rendered, then (a) upon the date the Illinois
19 Department or a governmental unit mails to the vendor
20 information that it is paying a bill in part or is refusing to
21 pay a bill in whole or in part, or (b) upon the date one year
22 following the date the vendor submitted such bill if the
23 Illinois Department or a governmental unit fails to mail to the
24 vendor such payment information within one year following the
25 date the vendor submitted the bill; or

26 (2) If the vendor cannot prove that he submitted a bill for

1 the service rendered within 180 days after ~~12 months of~~ the
2 date the service was rendered, then upon the date 12 months
3 following the date the vendor rendered the service to the
4 recipient.

5 In the case of long term care facilities, where the
6 Illinois Department initiates the monthly billing process for
7 the vendor, the cause of action shall accrue 12 months after
8 the last day of the month the service was rendered.

9 This paragraph governs only vendor payments as defined in
10 this Code and as limited by regulations of the Illinois
11 Department; it does not apply to goods or services purchased or
12 contracted for by a recipient under circumstances in which the
13 payment is to be made directly by the recipient.

14 Any vendor who accepts a vendor payment and who knowingly
15 obtains or attempts to obtain additional payment for the goods
16 or services covered by the vendor payment from the recipient or
17 any other person shall be guilty of a Class B misdemeanor.

18 (Source: P.A. 86-430.)

19 (305 ILCS 5/11-26) (from Ch. 23, par. 11-26)

20 Sec. 11-26. Recipient's abuse of medical care;
21 restrictions on access to medical care.

22 (a) When the Department determines, on the basis of
23 statistical norms and medical judgment, that a medical care
24 recipient has received medical services in excess of need and
25 with such frequency or in such a manner as to constitute an

1 abuse of the recipient's medical care privileges, the
2 recipient's access to medical care may be restricted.

3 (b) When the Department has determined that a recipient is
4 abusing his or her medical care privileges as described in this
5 Section, it may require that the recipient designate a primary
6 provider type of the recipient's own choosing to assume
7 responsibility for the recipient's care. For the purposes of
8 this subsection, "primary provider type" means a provider type
9 as determined by the Department ~~primary care provider, primary~~
10 ~~care pharmacy, primary dentist, primary podiatrist, or primary~~
11 ~~durable medical equipment provider~~. Instead of requiring a
12 recipient to make a designation as provided in this subsection,
13 the Department, pursuant to rules adopted by the Department and
14 without regard to any choice of an entity that the recipient
15 might otherwise make, may initially designate a primary
16 provider type provided that the primary provider type is
17 willing to provide that care.

18 (c) When the Department has requested that a recipient
19 designate a primary provider type and the recipient fails or
20 refuses to do so, the Department may, after a reasonable period
21 of time, assign the recipient to a primary provider type of its
22 own choice and determination, provided such primary provider
23 type is willing to provide such care.

24 (d) When a recipient has been restricted to a designated
25 primary provider type, the recipient may change the primary
26 provider type:

1 (1) when the designated source becomes unavailable, as
2 the Department shall determine by rule; or

3 (2) when the designated primary provider type notifies
4 the Department that it wishes to withdraw from any
5 obligation as primary provider type; or

6 (3) in other situations, as the Department shall
7 provide by rule.

8 The Department shall, by rule, establish procedures for
9 providing medical or pharmaceutical services when the
10 designated source becomes unavailable or wishes to withdraw
11 from any obligation as primary provider type, shall, by rule,
12 take into consideration the need for emergency or temporary
13 medical assistance and shall ensure that the recipient has
14 continuous and unrestricted access to medical care from the
15 date on which such unavailability or withdrawal becomes
16 effective until such time as the recipient designates a primary
17 provider type or a primary provider type willing to provide
18 such care is designated by the Department consistent with
19 subsections (b) and (c) and such restriction becomes effective.

20 (e) Prior to initiating any action to restrict a
21 recipient's access to medical or pharmaceutical care, the
22 Department shall notify the recipient of its intended action.
23 Such notification shall be in writing and shall set forth the
24 reasons for and nature of the proposed action. In addition, the
25 notification shall:

26 (1) inform the recipient that (i) the recipient has a

1 right to designate a primary provider type of the
2 recipient's own choosing willing to accept such
3 designation and that the recipient's failure to do so
4 within a reasonable time may result in such designation
5 being made by the Department or (ii) the Department has
6 designated a primary provider type to assume
7 responsibility for the recipient's care; and

8 (2) inform the recipient that the recipient has a right
9 to appeal the Department's determination to restrict the
10 recipient's access to medical care and provide the
11 recipient with an explanation of how such appeal is to be
12 made. The notification shall also inform the recipient of
13 the circumstances under which unrestricted medical
14 eligibility shall continue until a decision is made on
15 appeal and that if the recipient chooses to appeal, the
16 recipient will be able to review the medical payment data
17 that was utilized by the Department to decide that the
18 recipient's access to medical care should be restricted.

19 (f) The Department shall, by rule or regulation, establish
20 procedures for appealing a determination to restrict a
21 recipient's access to medical care, which procedures shall, at
22 a minimum, provide for a reasonable opportunity to be heard
23 and, where the appeal is denied, for a written statement of the
24 reason or reasons for such denial.

25 (g) Except as otherwise provided in this subsection, when a
26 recipient has had his or her medical card restricted for 4 full

1 quarters (without regard to any period of ineligibility for
2 medical assistance under this Code, or any period for which the
3 recipient voluntarily terminates his or her receipt of medical
4 assistance, that may occur before the expiration of those 4
5 full quarters), the Department shall reevaluate the
6 recipient's medical usage to determine whether it is still in
7 excess of need and with such frequency or in such a manner as
8 to constitute an abuse of the receipt of medical assistance. If
9 it is still in excess of need, the restriction shall be
10 continued for another 4 full quarters. If it is no longer in
11 excess of need, the restriction shall be discontinued. If a
12 recipient's access to medical care has been restricted under
13 this Section and the Department then determines, either at
14 reevaluation or after the restriction has been discontinued, to
15 restrict the recipient's access to medical care a second or
16 subsequent time, the second or subsequent restriction may be
17 imposed for a period of more than 4 full quarters. If the
18 Department restricts a recipient's access to medical care for a
19 period of more than 4 full quarters, as determined by rule, the
20 Department shall reevaluate the recipient's medical usage
21 after the end of the restriction period rather than after the
22 end of 4 full quarters. The Department shall notify the
23 recipient, in writing, of any decision to continue the
24 restriction and the reason or reasons therefor. A "quarter",
25 for purposes of this Section, shall be defined as one of the
26 following 3-month periods of time: January-March, April-June,

1 July-September or October-December.

2 (h) In addition to any other recipient whose acquisition of
3 medical care is determined to be in excess of need, the
4 Department may restrict the medical care privileges of the
5 following persons:

6 (1) recipients found to have loaned or altered their
7 cards or misused or falsely represented medical coverage;

8 (2) recipients found in possession of blank or forged
9 prescription pads;

10 (3) recipients who knowingly assist providers in
11 rendering excessive services or defrauding the medical
12 assistance program.

13 The procedural safeguards in this Section shall apply to
14 the above individuals.

15 (i) Restrictions under this Section shall be in addition to
16 and shall not in any way be limited by or limit any actions
17 taken under Article VIII-A of this Code.

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

19 (305 ILCS 5/12-4.25) (from Ch. 23, par. 12-4.25)

20 Sec. 12-4.25. Medical assistance program; vendor
21 participation.

22 (A) The Illinois Department may deny, suspend, or terminate
23 the eligibility of any person, firm, corporation, association,
24 agency, institution or other legal entity to participate as a
25 vendor of goods or services to recipients under the medical

1 assistance program under Article V, or may exclude any such
2 person or entity from participation as such a vendor, and may
3 deny, suspend, or recover payments, if after reasonable notice
4 and opportunity for a hearing the Illinois Department finds:

5 (a) Such vendor is not complying with the Department's
6 policy or rules and regulations, or with the terms and
7 conditions prescribed by the Illinois Department in its
8 vendor agreement, which document shall be developed by the
9 Department as a result of negotiations with each vendor
10 category, including physicians, hospitals, long term care
11 facilities, pharmacists, optometrists, podiatrists and
12 dentists setting forth the terms and conditions applicable
13 to the participation of each vendor group in the program;
14 or

15 (b) Such vendor has failed to keep or make available
16 for inspection, audit or copying, after receiving a written
17 request from the Illinois Department, such records
18 regarding payments claimed for providing services. This
19 section does not require vendors to make available patient
20 records of patients for whom services are not reimbursed
21 under this Code; or

22 (c) Such vendor has failed to furnish any information
23 requested by the Department regarding payments for
24 providing goods or services; or

25 (d) Such vendor has knowingly made, or caused to be
26 made, any false statement or representation of a material

1 fact in connection with the administration of the medical
2 assistance program; or

3 (e) Such vendor has furnished goods or services to a
4 recipient which are (1) in excess of need ~~his or her needs,~~
5 (2) harmful ~~to the recipient,~~ or (3) of grossly inferior
6 quality, all of such determinations to be based upon
7 competent medical judgment and evaluations; or

8 (f) The vendor; a person with management
9 responsibility for a vendor; an officer or person owning,
10 either directly or indirectly, 5% or more of the shares of
11 stock or other evidences of ownership in a corporate
12 vendor; an owner of a sole proprietorship which is a
13 vendor; or a partner in a partnership which is a vendor,
14 either:

15 (1) was previously terminated, suspended, or
16 excluded from participation in the Illinois medical
17 assistance program, or was terminated, suspended, or
18 excluded from participation in another state or
19 federal medical assistance or health care program ~~a~~
20 ~~medical assistance program in another state that is of~~
21 ~~the same kind as the program of medical assistance~~
22 ~~provided under Article V of this Code; or~~

23 (2) was a person with management responsibility
24 for a vendor previously terminated, suspended, or
25 excluded from participation in the Illinois medical
26 assistance program, or terminated, suspended, or

1 excluded from participation in another state or
2 federal ~~a~~ medical assistance or health care program ~~in~~
3 ~~another state that is of the same kind as the program~~
4 ~~of medical assistance provided under Article V of this~~
5 ~~Code,~~ during the time of conduct which was the basis
6 for that vendor's termination, suspension, or
7 exclusion; or

8 (3) was an officer, or person owning, either
9 directly or indirectly, 5% or more of the shares of
10 stock or other evidences of ownership in a corporate or
11 limited liability company vendor previously
12 terminated, suspended, or excluded from participation
13 in the Illinois medical assistance program, or
14 terminated, suspended, or excluded from participation
15 in a state or federal medical assistance or health care
16 program ~~in another state that is of the same kind as~~
17 ~~the program of medical assistance provided under~~
18 ~~Article V of this Code,~~ during the time of conduct
19 which was the basis for that vendor's termination, suspension, or exclusion; or

21 (4) was an owner of a sole proprietorship or
22 partner of a partnership previously terminated, suspended, or excluded from participation in the
23 Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or
24 federal medical assistance or health care program ~~in~~

1 ~~another state that is of the same kind as the program~~
2 ~~of medical assistance provided under Article V of this~~
3 ~~Code,~~ during the time of conduct which was the basis
4 for that vendor's termination, suspension, or
5 exclusion; or

6 (f-1) Such vendor has a delinquent debt owed to the
7 Illinois Department; or

8 (g) The vendor; a person with management
9 responsibility for a vendor; an officer or person owning,
10 either directly or indirectly, 5% or more of the shares of
11 stock or other evidences of ownership in a corporate or
12 limited liability company vendor; an owner of a sole
13 proprietorship which is a vendor; or a partner in a
14 partnership which is a vendor, either:

15 (1) has engaged in practices prohibited by
16 applicable federal or State law or regulation ~~relating~~
17 ~~to the medical assistance program;~~ or

18 (2) was a person with management responsibility
19 for a vendor at the time that such vendor engaged in
20 practices prohibited by applicable federal or State
21 law or regulation ~~relating to the medical assistance~~
22 ~~program;~~ or

23 (3) was an officer, or person owning, either
24 directly or indirectly, 5% or more of the shares of
25 stock or other evidences of ownership in a vendor at
26 the time such vendor engaged in practices prohibited by

1 applicable federal or State law or regulation ~~relating~~
2 ~~to the medical assistance program~~; or

3 (4) was an owner of a sole proprietorship or
4 partner of a partnership which was a vendor at the time
5 such vendor engaged in practices prohibited by
6 applicable federal or State law or regulation ~~relating~~
7 ~~to the medical assistance program~~; or

8 (h) The direct or indirect ownership of the vendor
9 (including the ownership of a vendor that is a sole
10 proprietorship, a partner's interest in a vendor that is a
11 partnership, or ownership of 5% or more of the shares of
12 stock or other evidences of ownership in a corporate
13 vendor) has been transferred by an individual who is
14 terminated, suspended, or excluded or barred from
15 participating as a vendor to the individual's spouse,
16 child, brother, sister, parent, grandparent, grandchild,
17 uncle, aunt, niece, nephew, cousin, or relative by
18 marriage.

19 (A-5) The Illinois Department may deny, suspend, or
20 terminate the eligibility of any person, firm, corporation,
21 association, agency, institution, or other legal entity to
22 participate as a vendor of goods or services to recipients
23 under the medical assistance program under Article V, or may
24 exclude any such person or entity from participation as such a
25 vendor, if, after reasonable notice and opportunity for a
26 hearing, the Illinois Department finds that the vendor; a

1 person with management responsibility for a vendor; an officer
2 or person owning, either directly or indirectly, 5% or more of
3 the shares of stock or other evidences of ownership in a
4 corporate vendor; an owner of a sole proprietorship that is a
5 vendor; or a partner in a partnership that is a vendor has been
6 convicted of an ~~a felony~~ offense based on fraud or willful
7 misrepresentation related to any of the following:

8 (1) The medical assistance program under Article V of
9 this Code.

10 (2) A medical assistance or health care program in
11 another state ~~that is of the same kind as the program of~~
12 ~~medical assistance provided under Article V of this Code.~~

13 (3) The Medicare program under Title XVIII of the
14 Social Security Act.

15 (4) The provision of health care services.

16 (5) A violation of this Code, as provided in Article
17 VIIIA, or another state or federal medical assistance
18 program or health care program.

19 (A-10) The Illinois Department may deny, suspend, or
20 terminate the eligibility of any person, firm, corporation,
21 association, agency, institution, or other legal entity to
22 participate as a vendor of goods or services to recipients
23 under the medical assistance program under Article V, or may
24 exclude any such person or entity from participation as such a
25 vendor, if, after reasonable notice and opportunity for a
26 hearing, the Illinois Department finds that (i) the vendor,

1 (ii) a person with management responsibility for a vendor,
2 (iii) an officer or person owning, either directly or
3 indirectly, 5% or more of the shares of stock or other
4 evidences of ownership in a corporate vendor, (iv) an owner of
5 a sole proprietorship that is a vendor, or (v) a partner in a
6 partnership that is a vendor has been convicted of an a-felony
7 offense related to any of the following:

8 (1) Murder.

9 (2) A Class X felony under the Criminal Code of 1961.

10 (3) Sexual misconduct that may subject recipients to an
11 undue risk of harm.

12 (4) A criminal offense that may subject recipients to
13 an undue risk of harm.

14 (5) A crime of fraud or dishonesty.

15 (6) A crime involving a controlled substance.

16 (7) A misdemeanor relating to fraud, theft,
17 embezzlement, breach of fiduciary responsibility, or other
18 financial misconduct related to a health care program.

19 (A-15) The Illinois Department may deny the eligibility of
20 any person, firm, corporation, association, agency,
21 institution, or other legal entity to participate as a vendor
22 of goods or services to recipients under the medical assistance
23 program under Article V if, after reasonable notice and
24 opportunity for a hearing, the Illinois Department finds:

25 (1) The applicant or any person with management
26 responsibility for the applicant; an officer or member of

1 the board of directors of an applicant; an entity owning
2 (directly or indirectly) 5% or more of the shares of stock
3 or other evidences of ownership in a corporate vendor
4 applicant; an owner of a sole proprietorship applicant; a
5 partner in a partnership applicant; or a technical or other
6 advisor to an applicant has a debt owed to the Illinois
7 Department, and no payment arrangements acceptable to the
8 Illinois Department have been made by the applicant.

9 (2) The applicant or any person with management
10 responsibility for the applicant; an officer or member of
11 the board of directors of an applicant; an entity owning
12 (directly or indirectly) 5% or more of the shares of stock
13 or other evidences of ownership in a corporate vendor
14 applicant; an owner of a sole proprietorship applicant; a
15 partner in a partnership vendor applicant; or a technical
16 or other advisor to an applicant was (i) a person with
17 management responsibility, (ii) an officer or member of the
18 board of directors of an applicant, (iii) an entity owning
19 (directly or indirectly) 5% or more of the shares of stock
20 or other evidences of ownership in a corporate vendor, (iv)
21 an owner of a sole proprietorship, (v) a partner in a
22 partnership vendor, (vi) a technical or other advisor to a
23 vendor, during a period of time where the conduct of that
24 vendor resulted in a debt owed to the Illinois Department,
25 and no payment arrangements acceptable to the Illinois
26 Department have been made by that vendor.

1 (3) There is a credible allegation of the use,
2 transfer, or lease of assets of any kind to an applicant
3 from a current or prior vendor who has a debt owed to the
4 Illinois Department, no payment arrangements acceptable to
5 the Illinois Department have been made by that vendor or
6 the vendor's alternate payee, and the applicant knows or
7 should have known of such debt.

8 (4) There is a credible allegation of a transfer of
9 management responsibilities, or direct or indirect
10 ownership, to an applicant from a current or prior vendor
11 who has a debt owed to the Illinois Department, and no
12 payment arrangements acceptable to the Illinois Department
13 have been made by that vendor or the vendor's alternate
14 payee, and the applicant knows or should have known of such
15 debt.

16 (5) There is a credible allegation of the use,
17 transfer, or lease of assets of any kind to an applicant
18 who is a spouse, child, brother, sister, parent,
19 grandparent, grandchild, uncle, aunt, niece, relative by
20 marriage, nephew, cousin, or relative of a current or prior
21 vendor who has a debt owed to the Illinois Department and
22 no payment arrangements acceptable to the Illinois
23 Department have been made.

24 (6) There is a credible allegation that the applicant's
25 previous affiliations with a provider of medical services
26 that has an uncollected debt, a provider that has been or

1 is subject to a payment suspension under a federal health
2 care program, or a provider that has been previously
3 excluded from participation in the medical assistance
4 program, poses a risk of fraud, waste, or abuse to the
5 Illinois Department.

6 As used in this subsection, "credible allegation" is
7 defined to include an allegation from any source, including,
8 but not limited to, fraud hotline complaints, claims data
9 mining, patterns identified through provider audits, civil
10 actions filed under the False Claims Act, and law enforcement
11 investigations. An allegation is considered to be credible when
12 it has indicia of reliability.

13 (B) The Illinois Department shall deny, suspend or
14 terminate the eligibility of any person, firm, corporation,
15 association, agency, institution or other legal entity to
16 participate as a vendor of goods or services to recipients
17 under the medical assistance program under Article V, or may
18 exclude any such person or entity from participation as such a
19 vendor:

20 (1) immediately, if such vendor is not properly
21 licensed, certified, or authorized;

22 (2) within 30 days of the date when such vendor's
23 professional license, certification or other authorization
24 has been refused renewal, restricted, ~~or has been~~ revoked,
25 suspended, or otherwise terminated; or

26 (3) if such vendor has been convicted of a violation of

1 this Code, as provided in Article VIIIA.

2 (C) Upon termination, suspension, or exclusion of a vendor
3 of goods or services from participation in the medical
4 assistance program authorized by this Article, a person with
5 management responsibility for such vendor during the time of
6 any conduct which served as the basis for that vendor's
7 termination, suspension, or exclusion is barred from
8 participation in the medical assistance program.

9 Upon termination, suspension, or exclusion of a corporate
10 vendor, the officers and persons owning, directly or
11 indirectly, 5% or more of the shares of stock or other
12 evidences of ownership in the vendor during the time of any
13 conduct which served as the basis for that vendor's
14 termination, suspension, or exclusion are barred from
15 participation in the medical assistance program. A person who
16 owns, directly or indirectly, 5% or more of the shares of stock
17 or other evidences of ownership in a terminated, suspended, or
18 excluded ~~corporate~~ vendor may not transfer his or her ownership
19 interest in that vendor to his or her spouse, child, brother,
20 sister, parent, grandparent, grandchild, uncle, aunt, niece,
21 nephew, cousin, or relative by marriage.

22 Upon termination, suspension, or exclusion of a sole
23 proprietorship or partnership, the owner or partners during the
24 time of any conduct which served as the basis for that vendor's
25 termination, suspension, or exclusion are barred from
26 participation in the medical assistance program. The owner of a

1 terminated, suspended, or excluded vendor that is a sole
2 proprietorship, and a partner in a terminated, suspended, or
3 excluded vendor that is a partnership, may not transfer his or
4 her ownership or partnership interest in that vendor to his or
5 her spouse, child, brother, sister, parent, grandparent,
6 grandchild, uncle, aunt, niece, nephew, cousin, or relative by
7 marriage.

8 A person who owns, directly or indirectly, 5% or more of
9 the shares of stock or other evidences of ownership in a
10 corporate or limited liability company vendor who owes a debt
11 to the Department, if that vendor has not made payment
12 arrangements acceptable to the Department, shall not transfer
13 his or her ownership interest in that vendor, or vendor assets
14 of any kind, to his or her spouse, child, brother, sister,
15 parent, grandparent, grandchild, uncle, aunt, niece, nephew,
16 cousin, or relative by marriage.

17 Rules adopted by the Illinois Department to implement these
18 provisions shall specifically include a definition of the term
19 "management responsibility" as used in this Section. Such
20 definition shall include, but not be limited to, typical job
21 titles, and duties and descriptions which will be considered as
22 within the definition of individuals with management
23 responsibility for a provider.

24 A vendor or a prior vendor who has been terminated,
25 excluded, or suspended from the medical assistance program, or
26 from another state or federal medical assistance or health care

1 program, and any individual currently or previously barred from
2 the medical assistance program, or from another state or
3 federal medical assistance or health care program, as a result
4 of being an officer or a person owning, directly or indirectly,
5 5% or more of the shares of stock or other evidences of
6 ownership in a corporate or limited liability company vendor
7 during the time of any conduct which served as the basis for
8 that vendor's termination, suspension, or exclusion, may be
9 required to post a surety bond as part of a condition of
10 enrollment or participation in the medical assistance program.
11 The Illinois Department shall establish, by rule, the criteria
12 and requirements for determining when a surety bond must be
13 posted and the value of the bond.

14 A vendor or a prior vendor who has a debt owed to the
15 Illinois Department and any individual currently or previously
16 barred from the medical assistance program, or from another
17 state or federal medical assistance or health care program, as
18 a result of being an officer or a person owning, directly or
19 indirectly, 5% or more of the shares of stock or other
20 evidences of ownership in that corporate or limited liability
21 company vendor during the time of any conduct which served as
22 the basis for the debt, may be required to post a surety bond
23 as part of a condition of enrollment or participation in the
24 medical assistance program. The Illinois Department shall
25 establish, by rule, the criteria and requirements for
26 determining when a surety bond must be posted and the value of

1 the bond.

2 (D) If a vendor has been suspended from the medical
3 assistance program under Article V of the Code, the Director
4 may require that such vendor correct any deficiencies which
5 served as the basis for the suspension. The Director shall
6 specify in the suspension order a specific period of time,
7 which shall not exceed one year from the date of the order,
8 during which a suspended vendor shall not be eligible to
9 participate. At the conclusion of the period of suspension the
10 Director shall reinstate such vendor, unless he finds that such
11 vendor has not corrected deficiencies upon which the suspension
12 was based.

13 If a vendor has been terminated, suspended, or excluded
14 from the medical assistance program under Article V, such
15 vendor shall be barred from participation for at least one
16 year, except that if a vendor has been terminated, suspended,
17 or excluded based on a conviction of a violation of Article
18 VIIIA or a conviction of a felony based on fraud or a willful
19 misrepresentation related to (i) the medical assistance
20 program under Article V, (ii) a federal or another state's
21 medical assistance or health care program in another state that
22 ~~is of the kind provided under Article V, (iii) the Medicare~~
23 ~~program under Title XVIII of the Social Security Act, or (iii)~~
24 ~~(iv)~~ the provision of health care services, then the vendor
25 shall be barred from participation for 5 years or for the
26 length of the vendor's sentence for that conviction, whichever

1 is longer. At the end of one year a vendor who has been
2 terminated, suspended, or excluded may apply for reinstatement
3 to the program. Upon proper application to be reinstated such
4 vendor may be deemed eligible by the Director providing that
5 such vendor meets the requirements for eligibility under this
6 Code. If such vendor is deemed not eligible for reinstatement,
7 he shall be barred from again applying for reinstatement for
8 one year from the date his application for reinstatement is
9 denied.

10 A vendor whose termination, suspension, or exclusion from
11 participation in the Illinois medical assistance program under
12 Article V was based solely on an action by a governmental
13 entity other than the Illinois Department may, upon
14 reinstatement by that governmental entity or upon reversal of
15 the termination, suspension, or exclusion, apply for
16 rescission of the termination, suspension, or exclusion from
17 participation in the Illinois medical assistance program. Upon
18 proper application for rescission, the vendor may be deemed
19 eligible by the Director if the vendor meets the requirements
20 for eligibility under this Code.

21 If a vendor has been terminated, suspended, or excluded and
22 reinstated to the medical assistance program under Article V
23 and the vendor is terminated, suspended, or excluded a second
24 or subsequent time from the medical assistance program, the
25 vendor shall be barred from participation for at least 2 years,
26 except that if a vendor has been terminated, suspended, or

1 excluded a second time based on a conviction of a violation of
2 Article VIIIA or a conviction of a felony based on fraud or a
3 willful misrepresentation related to (i) the medical
4 assistance program under Article V, (ii) a federal or another
5 state's medical assistance or health care program ~~in another~~
6 ~~state that is of the kind provided under Article V, (iii) the~~
7 ~~Medicare program under Title XVIII of the Social Security Act,~~
8 or (iii) ~~(iv)~~ the provision of health care services, then the
9 vendor shall be barred from participation for life. At the end
10 of 2 years, a vendor who has been terminated, suspended, or
11 excluded may apply for reinstatement to the program. Upon
12 application to be reinstated, the vendor may be deemed eligible
13 if the vendor meets the requirements for eligibility under this
14 Code. If the vendor is deemed not eligible for reinstatement,
15 the vendor shall be barred from again applying for
16 reinstatement for 2 years from the date the vendor's
17 application for reinstatement is denied.

18 (E) The Illinois Department may recover money improperly or
19 erroneously paid, or overpayments, either by setoff, crediting
20 against future billings or by requiring direct repayment to the
21 Illinois Department. The Illinois Department may suspend or
22 deny payment, in whole or in part, if such payment would be
23 improper or erroneous or would otherwise result in overpayment.

24 (1) Payments may be suspended, denied, or recovered
25 from a vendor or alternate payee: (i) for services rendered
26 in violation of the Illinois Department's provider

1 notices, statutes, rules, and regulations; (ii) for
2 services rendered in violation of the terms and conditions
3 prescribed by the Illinois Department in its vendor
4 agreement; (iii) for any vendor who fails to grant the
5 Office of Inspector General timely access to full and
6 complete records, including, but not limited to, records
7 relating to recipients under the medical assistance
8 program for the most recent 6 years, in accordance with
9 Section 140.28 of Title 89 of the Illinois Administrative
10 Code, and other information for the purpose of audits,
11 investigations, or other program integrity functions,
12 after reasonable written request by the Inspector General;
13 this subsection (E) does not require vendors to make
14 available the medical records of patients for whom services
15 are not reimbursed under this Code or to provide access to
16 medical records more than 6 years old; (iv) when the vendor
17 has knowingly made, or caused to be made, any false
18 statement or representation of a material fact in
19 connection with the administration of the medical
20 assistance program; or (v) when the vendor previously
21 rendered services while terminated, suspended, or excluded
22 from participation in the medical assistance program or
23 while terminated or excluded from participation in another
24 state or federal medical assistance or health care program.

25 (2) Notwithstanding any other provision of law, if a
26 vendor has the same taxpayer identification number

1 (assigned under Section 6109 of the Internal Revenue Code
2 of 1986) as is assigned to a vendor with past-due financial
3 obligations to the Illinois Department, the Illinois
4 Department may make any necessary adjustments to payments
5 to that vendor in order to satisfy any past-due
6 obligations, regardless of whether the vendor is assigned a
7 different billing number under the medical assistance
8 program.

9 If the Illinois Department establishes through an
10 administrative hearing that the overpayments resulted from the
11 vendor or alternate payee knowingly ~~willfully~~ making, using, or
12 causing to be made or used, a false record or statement to
13 obtain payment or other benefit from ~~or misrepresentation of a~~
14 ~~material fact in connection with billings and payments under~~
15 the medical assistance program under Article V, the Department
16 may recover interest on the amount of the payment or other
17 benefit ~~overpayments~~ at the rate of 5% per annum. In addition
18 to any other penalties that may be prescribed by law, such a
19 vendor or alternate payee shall be subject to civil penalties
20 consisting of an amount not to exceed 3 times the amount of
21 payment or other benefit resulting from each such false record
22 or statement, and the sum of \$2,000 for each such false record
23 or statement for payment or other benefit. For purposes of this
24 paragraph, "knowingly" ~~"willfully"~~ means that a vendor or
25 alternate payee with respect to information: (i) has ~~person~~
26 ~~makes a statement or representation with actual knowledge of~~

1 the information, (ii) acts in deliberate ignorance of the truth
2 or falsity of the information, or (iii) acts in reckless
3 disregard of the truth or falsity of the information. No proof
4 of specific intent to defraud is required. ~~that it was false,~~
5 ~~or makes a statement or representation with knowledge of facts~~
6 ~~or information that would cause one to be aware that the~~
7 ~~statement or representation was false when made.~~

8 (F) The Illinois Department may withhold payments to any
9 vendor or alternate payee prior to or during the pendency of
10 any audit or proceeding under this Section, and through the
11 pendency of any administrative appeal or administrative review
12 by any court proceeding. The Illinois Department shall state by
13 rule with as much specificity as practicable the conditions
14 under which payments will not be withheld ~~during the pendency~~
15 ~~of any proceeding~~ under this Section. Payments may be denied
16 for bills submitted with service dates occurring during the
17 pendency of a proceeding, after a final decision has been
18 rendered, or after the conclusion of any administrative appeal,
19 where the final administrative decision is to terminate,
20 exclude, or suspend eligibility to participate in the medical
21 assistance program. The Illinois Department shall state by rule
22 with as much specificity as practicable the conditions under
23 which payments will not be denied for such bills. The Illinois
24 Department shall state by rule a process and criteria by which
25 a vendor or alternate payee may request full or partial release
26 of payments withheld under this subsection. The Department must

1 complete a proceeding under this Section in a timely manner.

2 Notwithstanding recovery allowed under subsection (E) or
3 this subsection (F), the Illinois Department may withhold
4 payments to any vendor or alternate payee who is not properly
5 licensed, certified, or in compliance with State or federal
6 agency regulations. Payments may be denied for bills submitted
7 with service dates occurring during the period of time that a
8 vendor is not properly licensed, certified, or in compliance
9 with State or federal regulations. Facilities licensed under
10 the Nursing Home Care Act shall have payments denied or
11 withheld pursuant to subsection (I) of this Section.

12 (F-5) The Illinois Department may temporarily withhold
13 payments to a vendor or alternate payee if any of the following
14 individuals have been indicted or otherwise charged under a law
15 of the United States or this or any other state with an a
16 ~~felony~~ offense that is based on alleged fraud or willful
17 misrepresentation on the part of the individual related to (i)
18 the medical assistance program under Article V of this Code,
19 (ii) a federal or another state's medical assistance or health
20 care program ~~provided in another state which is of the kind~~
21 ~~provided under Article V of this Code, (iii) the Medicare~~
22 ~~program under Title XVIII of the Social Security Act, or (iii)~~
23 ~~(iv)~~ the provision of health care services:

24 (1) If the vendor or alternate payee is a corporation:
25 an officer of the corporation or an individual who owns,
26 either directly or indirectly, 5% or more of the shares of

1 stock or other evidence of ownership of the corporation.

2 (2) If the vendor is a sole proprietorship: the owner
3 of the sole proprietorship.

4 (3) If the vendor or alternate payee is a partnership:
5 a partner in the partnership.

6 (4) If the vendor or alternate payee is any other
7 business entity authorized by law to transact business in
8 this State: an officer of the entity or an individual who
9 owns, either directly or indirectly, 5% or more of the
10 evidences of ownership of the entity.

11 If the Illinois Department withholds payments to a vendor
12 or alternate payee under this subsection, the Department shall
13 not release those payments to the vendor or alternate payee
14 while any criminal proceeding related to the indictment or
15 charge is pending unless the Department determines that there
16 is good cause to release the payments before completion of the
17 proceeding. If the indictment or charge results in the
18 individual's conviction, the Illinois Department shall retain
19 all withheld payments, which shall be considered forfeited to
20 the Department. If the indictment or charge does not result in
21 the individual's conviction, the Illinois Department shall
22 release to the vendor or alternate payee all withheld payments.

23 (F-10) If the Illinois Department establishes that the
24 vendor or alternate payee owes a debt to the Illinois
25 Department, and the vendor or alternate payee subsequently
26 fails to pay or make satisfactory payment arrangements with the

1 Illinois Department for the debt owed, the Illinois Department
2 may seek all remedies available under the law of this State to
3 recover the debt, including, but not limited to, wage
4 garnishment or the filing of claims or liens against the vendor
5 or alternate payee.

6 (F-15) Enforcement of judgment.

7 (1) Any fine, recovery amount, other sanction, or costs
8 imposed, or part of any fine, recovery amount, other
9 sanction, or cost imposed, remaining unpaid after the
10 exhaustion of or the failure to exhaust judicial review
11 procedures under the Illinois Administrative Review Law is
12 a debt due and owing the State and may be collected using
13 all remedies available under the law.

14 (2) After expiration of the period in which judicial
15 review under the Illinois Administrative Review Law may be
16 sought for a final administrative decision, unless stayed
17 by a court of competent jurisdiction, the findings,
18 decision, and order of the Director may be enforced in the
19 same manner as a judgment entered by a court of competent
20 jurisdiction.

21 (3) In any case in which any person or entity has
22 failed to comply with a judgment ordering or imposing any
23 fine or other sanction, any expenses incurred by the
24 Illinois Department to enforce the judgment, including,
25 but not limited to, attorney's fees, court costs, and costs
26 related to property demolition or foreclosure, after they

1 are fixed by a court of competent jurisdiction or the
2 Director, shall be a debt due and owing the State and may
3 be collected in accordance with applicable law. Prior to
4 any expenses being fixed by a final administrative decision
5 pursuant to this subsection (F-15), the Illinois
6 Department shall provide notice to the individual or entity
7 that states that the individual or entity shall appear at a
8 hearing before the administrative hearing officer to
9 determine whether the individual or entity has failed to
10 comply with the judgment. The notice shall set the date for
11 such a hearing, which shall not be less than 7 days from
12 the date that notice is served. If notice is served by
13 mail, the 7-day period shall begin to run on the date that
14 the notice was deposited in the mail.

15 (4) Upon being recorded in the manner required by
16 Article XII of the Code of Civil Procedure or by the
17 Uniform Commercial Code, a lien shall be imposed on the
18 real estate or personal estate, or both, of the individual
19 or entity in the amount of any debt due and owing the State
20 under this Section. The lien may be enforced in the same
21 manner as a judgment of a court of competent jurisdiction.
22 A lien shall attach to all property and assets of such
23 person, firm, corporation, association, agency,
24 institution, or other legal entity until the judgment is
25 satisfied.

26 (5) The Director may set aside any judgment entered by

1 default and set a new hearing date upon a petition filed at
2 any time (i) if the petitioner's failure to appear at the
3 hearing was for good cause, or (ii) if the petitioner
4 established that the Department did not provide proper
5 service of process. If any judgment is set aside pursuant
6 to this paragraph (5), the hearing officer shall have
7 authority to enter an order extinguishing any lien which
8 has been recorded for any debt due and owing the Illinois
9 Department as a result of the vacated default judgment.

10 (G) The provisions of the Administrative Review Law, as now
11 or hereafter amended, and the rules adopted pursuant thereto,
12 shall apply to and govern all proceedings for the judicial
13 review of final administrative decisions of the Illinois
14 Department under this Section. The term "administrative
15 decision" is defined as in Section 3-101 of the Code of Civil
16 Procedure.

17 (G-5) Vendors who pose a risk of fraud, waste, abuse, or
18 harm ~~Non-emergency transportation.~~

19 (1) Notwithstanding any other provision in this
20 Section, ~~for non-emergency transportation vendors,~~ the
21 Department may terminate, suspend, or exclude vendors who
22 pose a risk of fraud, waste, abuse, or harm ~~the vendor~~ from
23 participation in the medical assistance program prior to an
24 evidentiary hearing but after reasonable notice and
25 opportunity to respond as established by the Department by
26 rule.

1 (2) Vendors who pose a risk of fraud, waste, abuse, or
2 harm of non-emergency medical transportation services, as
3 defined by the Department by rule, shall submit to a
4 fingerprint-based criminal background check on current and
5 future information available in the State system and
6 current information available through the Federal Bureau
7 of Investigation's system by submitting all necessary fees
8 and information in the form and manner prescribed by the
9 Department of State Police. The following individuals
10 shall be subject to the check:

11 (A) In the case of a vendor that is a corporation,
12 every shareholder who owns, directly or indirectly, 5%
13 or more of the outstanding shares of the corporation.

14 (B) In the case of a vendor that is a partnership,
15 every partner.

16 (C) In the case of a vendor that is a sole
17 proprietorship, the sole proprietor.

18 (D) Each officer or manager of the vendor.

19 Each such vendor shall be responsible for payment of
20 the cost of the criminal background check.

21 (3) Vendors who pose a risk of fraud, waste, abuse, or
22 harm of non-emergency medical transportation services may
23 be required to post a surety bond. The Department shall
24 establish, by rule, the criteria and requirements for
25 determining when a surety bond must be posted and the value
26 of the bond.

1 (4) The Department, or its agents, may refuse to accept
2 requests for authorization from specific vendors who pose a
3 risk of fraud, waste, abuse, or harm ~~non-emergency~~
4 ~~transportation authorizations~~, including prior-approval
5 and post-approval requests, ~~for a specific non-emergency~~
6 ~~transportation vendor~~ if:

7 (A) the Department has initiated a notice of
8 termination, suspension, or exclusion of the vendor
9 from participation in the medical assistance program;
10 or

11 (B) the Department has issued notification of its
12 withholding of payments pursuant to subsection (F-5)
13 of this Section; or

14 (C) the Department has issued a notification of its
15 withholding of payments due to reliable evidence of
16 fraud or willful misrepresentation pending
17 investigation.

18 (5) As used in this subsection, the following terms are
19 defined as follows:

20 (A) "Fraud" means an intentional deception or
21 misrepresentation made by a person with the knowledge
22 that the deception could result in some unauthorized
23 benefit to himself or herself or some other person. It
24 includes any act that constitutes fraud under
25 applicable federal or State law.

26 (B) "Abuse" means provider practices that are

1 inconsistent with sound fiscal, business, or medical
2 practices and that result in an unnecessary cost to the
3 medical assistance program or in reimbursement for
4 services that are not medically necessary or that fail
5 to meet professionally recognized standards for health
6 care. It also includes recipient practices that result
7 in unnecessary cost to the medical assistance program.
8 Abuse does not include diagnostic or therapeutic
9 measures conducted primarily as a safeguard against
10 possible vendor liability.

11 (C) "Waste" means the unintentional misuse of
12 medical assistance resources, resulting in unnecessary
13 cost to the medical assistance program. Waste does not
14 include diagnostic or therapeutic measures conducted
15 primarily as a safeguard against possible vendor
16 liability.

17 (D) "Harm" means physical, mental, or monetary
18 damage to recipients or to the medical assistance
19 program.

20 (G-6) The Illinois Department, upon making a determination
21 based upon information in the possession of the Illinois
22 Department that continuation of participation in the medical
23 assistance program by a vendor would constitute an immediate
24 danger to the public, may immediately suspend such vendor's
25 participation in the medical assistance program without a
26 hearing. In instances in which the Illinois Department

1 immediately suspends the medical assistance program
2 participation of a vendor under this Section, a hearing upon
3 the vendor's participation must be convened by the Illinois
4 Department within 15 days after such suspension and completed
5 without appreciable delay. Such hearing shall be held to
6 determine whether to recommend to the Director that the
7 vendor's medical assistance program participation be denied,
8 terminated, suspended, placed on provisional status, or
9 reinstated. In the hearing, any evidence relevant to the vendor
10 constituting an immediate danger to the public may be
11 introduced against such vendor; provided, however, that the
12 vendor, or his or her counsel, shall have the opportunity to
13 discredit, impeach, and submit evidence rebutting such
14 evidence.

15 (H) Nothing contained in this Code shall in any way limit
16 or otherwise impair the authority or power of any State agency
17 responsible for licensing of vendors.

18 (I) Based on a finding of noncompliance on the part of a
19 nursing home with any requirement for certification under Title
20 XVIII or XIX of the Social Security Act (42 U.S.C. Sec. 1395 et
21 seq. or 42 U.S.C. Sec. 1396 et seq.), the Illinois Department
22 may impose one or more of the following remedies after notice
23 to the facility:

- 24 (1) Termination of the provider agreement.
25 (2) Temporary management.
26 (3) Denial of payment for new admissions.

1 (4) Civil money penalties.

2 (5) Closure of the facility in emergency situations or
3 transfer of residents, or both.

4 (6) State monitoring.

5 (7) Denial of all payments when the U.S. Department of
6 Health and Human Services ~~Health Care Finance~~
7 ~~Administration~~ has imposed this sanction.

8 The Illinois Department shall by rule establish criteria
9 governing continued payments to a nursing facility subsequent
10 to termination of the facility's provider agreement if, in the
11 sole discretion of the Illinois Department, circumstances
12 affecting the health, safety, and welfare of the facility's
13 residents require those continued payments. The Illinois
14 Department may condition those continued payments on the
15 appointment of temporary management, sale of the facility to
16 new owners or operators, or other arrangements that the
17 Illinois Department determines best serve the needs of the
18 facility's residents.

19 Except in the case of a facility that has a right to a
20 hearing on the finding of noncompliance before an agency of the
21 federal government, a facility may request a hearing before a
22 State agency on any finding of noncompliance within 60 days
23 after the notice of the intent to impose a remedy. Except in
24 the case of civil money penalties, a request for a hearing
25 shall not delay imposition of the penalty. The choice of
26 remedies is not appealable at a hearing. The level of

1 noncompliance may be challenged only in the case of a civil
2 money penalty. The Illinois Department shall provide by rule
3 for the State agency that will conduct the evidentiary
4 hearings.

5 The Illinois Department may collect interest on unpaid
6 civil money penalties.

7 The Illinois Department may adopt all rules necessary to
8 implement this subsection (I).

9 (J) The Illinois Department, by rule, may permit individual
10 practitioners to designate that Department payments that may be
11 due the practitioner be made to an alternate payee or alternate
12 payees.

13 (a) Such alternate payee or alternate payees shall be
14 required to register as an alternate payee in the Medical
15 Assistance Program with the Illinois Department.

16 (b) If a practitioner designates an alternate payee,
17 the alternate payee and practitioner shall be jointly and
18 severally liable to the Department for payments made to the
19 alternate payee. Pursuant to subsection (E) of this
20 Section, any Department action to suspend or deny payment
21 or recover money or overpayments from an alternate payee
22 shall be subject to an administrative hearing.

23 (c) Registration as an alternate payee or alternate
24 payees in the Illinois Medical Assistance Program shall be
25 conditional. At any time, the Illinois Department may deny
26 or cancel any alternate payee's registration in the

1 Illinois Medical Assistance Program without cause. Any
2 such denial or cancellation is not subject to an
3 administrative hearing.

4 (d) The Illinois Department may seek a revocation of
5 any alternate payee, and all owners, officers, and
6 individuals with management responsibility for such
7 alternate payee shall be permanently prohibited from
8 participating as an owner, an officer, or an individual
9 with management responsibility with an alternate payee in
10 the Illinois Medical Assistance Program, if after
11 reasonable notice and opportunity for a hearing the
12 Illinois Department finds that:

13 (1) the alternate payee is not complying with the
14 Department's policy or rules and regulations, or with
15 the terms and conditions prescribed by the Illinois
16 Department in its alternate payee registration
17 agreement; or

18 (2) the alternate payee has failed to keep or make
19 available for inspection, audit, or copying, after
20 receiving a written request from the Illinois
21 Department, such records regarding payments claimed as
22 an alternate payee; or

23 (3) the alternate payee has failed to furnish any
24 information requested by the Illinois Department
25 regarding payments claimed as an alternate payee; or

26 (4) the alternate payee has knowingly made, or

1 caused to be made, any false statement or
2 representation of a material fact in connection with
3 the administration of the Illinois Medical Assistance
4 Program; or

5 (5) the alternate payee, a person with management
6 responsibility for an alternate payee, an officer or
7 person owning, either directly or indirectly, 5% or
8 more of the shares of stock or other evidences of
9 ownership in a corporate alternate payee, or a partner
10 in a partnership which is an alternate payee:

11 (a) was previously terminated, suspended, or
12 excluded from participation as a vendor in the
13 Illinois Medical Assistance Program, or was
14 previously revoked as an alternate payee in the
15 Illinois Medical Assistance Program, or was
16 terminated, suspended, or excluded from
17 participation as a vendor in a medical assistance
18 program in another state that is of the same kind
19 as the program of medical assistance provided
20 under Article V of this Code; or

21 (b) was a person with management
22 responsibility for a vendor previously terminated, suspended, or excluded
23 from participation as a
24 vendor in the Illinois Medical Assistance Program,
25 or was previously revoked as an alternate payee in
26 the Illinois Medical Assistance Program, or was

1 terminated, suspended, or excluded from
2 participation as a vendor in a medical assistance
3 program in another state that is of the same kind
4 as the program of medical assistance provided
5 under Article V of this Code, during the time of
6 conduct which was the basis for that vendor's
7 termination, suspension, or exclusion or alternate
8 payee's revocation; or

9 (c) was an officer, or person owning, either
10 directly or indirectly, 5% or more of the shares of
11 stock or other evidences of ownership in a
12 corporate vendor previously terminated, suspended,
13 or excluded from participation as a vendor in the
14 Illinois Medical Assistance Program, or was
15 previously revoked as an alternate payee in the
16 Illinois Medical Assistance Program, or was
17 terminated, suspended, or excluded from
18 participation as a vendor in a medical assistance
19 program in another state that is of the same kind
20 as the program of medical assistance provided
21 under Article V of this Code, during the time of
22 conduct which was the basis for that vendor's
23 termination, suspension, or exclusion; or

24 (d) was an owner of a sole proprietorship or
25 partner in a partnership previously terminated, ,
26 suspended, or excluded from participation as a

1 vendor in the Illinois Medical Assistance Program,
2 or was previously revoked as an alternate payee in
3 the Illinois Medical Assistance Program, or was
4 terminated, suspended, or excluded from
5 participation as a vendor in a medical assistance
6 program in another state that is of the same kind
7 as the program of medical assistance provided
8 under Article V of this Code, during the time of
9 conduct which was the basis for that vendor's
10 termination, termination, suspension, or exclusion or alternate
11 payee's revocation; or

12 (6) the alternate payee, a person with management
13 responsibility for an alternate payee, an officer or
14 person owning, either directly or indirectly, 5% or
15 more of the shares of stock or other evidences of
16 ownership in a corporate alternate payee, or a partner
17 in a partnership which is an alternate payee:

18 (a) has engaged in conduct prohibited by
19 applicable federal or State law or regulation
20 relating to the Illinois Medical Assistance
21 Program; or

22 (b) was a person with management
23 responsibility for a vendor or alternate payee at
24 the time that the vendor or alternate payee engaged
25 in practices prohibited by applicable federal or
26 State law or regulation relating to the Illinois

1 Medical Assistance Program; or

2 (c) was an officer, or person owning, either
3 directly or indirectly, 5% or more of the shares of
4 stock or other evidences of ownership in a vendor
5 or alternate payee at the time such vendor or
6 alternate payee engaged in practices prohibited by
7 applicable federal or State law or regulation
8 relating to the Illinois Medical Assistance
9 Program; or

10 (d) was an owner of a sole proprietorship or
11 partner in a partnership which was a vendor or
12 alternate payee at the time such vendor or
13 alternate payee engaged in practices prohibited by
14 applicable federal or State law or regulation
15 relating to the Illinois Medical Assistance
16 Program; or

17 (7) the direct or indirect ownership of the vendor
18 or alternate payee (including the ownership of a vendor
19 or alternate payee that is a partner's interest in a
20 vendor or alternate payee, or ownership of 5% or more
21 of the shares of stock or other evidences of ownership
22 in a corporate vendor or alternate payee) has been
23 transferred by an individual who is terminated,
24 suspended, or excluded or barred from participating as
25 a vendor or is prohibited or revoked as an alternate
26 payee to the individual's spouse, child, brother,

1 sister, parent, grandparent, grandchild, uncle, aunt,
2 niece, nephew, cousin, or relative by marriage.

3 (K) The Illinois Department of Healthcare and Family
4 Services may withhold payments, in whole or in part, to a
5 provider or alternate payee where there is credible ~~upon~~
6 ~~receipt~~ of evidence, received from State or federal law
7 enforcement or federal oversight agencies or from the results
8 of a preliminary Department audit ~~and determined by the~~
9 ~~Department to be credible~~, that the circumstances giving rise
10 to the need for a withholding of payments may involve fraud or
11 willful misrepresentation under the Illinois Medical
12 Assistance program. The Department shall by rule define what
13 constitutes "credible" evidence for purposes of this
14 subsection. The Department may withhold payments without first
15 notifying the provider or alternate payee of its intention to
16 withhold such payments. A provider or alternate payee may
17 request a reconsideration of payment withholding, and the
18 Department must grant such a request. The Department shall
19 state by rule a process and criteria by which a provider or
20 alternate payee may request full or partial release of payments
21 withheld under this subsection. This request may be made at any
22 time after the Department first withholds such payments.

23 (a) The Illinois Department must send notice of its
24 withholding of program payments within 5 days of taking
25 such action. The notice must set forth the general
26 allegations as to the nature of the withholding action, but

1 need not disclose any specific information concerning its
2 ongoing investigation. The notice must do all of the
3 following:

4 (1) State that payments are being withheld in
5 accordance with this subsection.

6 (2) State that the withholding is for a temporary
7 period, as stated in paragraph (b) of this subsection,
8 and cite the circumstances under which withholding
9 will be terminated.

10 (3) Specify, when appropriate, which type or types
11 of Medicaid claims withholding is effective.

12 (4) Inform the provider or alternate payee of the
13 right to submit written evidence for reconsideration
14 of the withholding by the Illinois Department.

15 (5) Inform the provider or alternate payee that a
16 written request may be made to the Illinois Department
17 for full or partial release of withheld payments and
18 that such requests may be made at any time after the
19 Department first withholds such payments.

20 (b) All withholding-of-payment actions under this
21 subsection shall be temporary and shall not continue after
22 any of the following:

23 (1) The Illinois Department or the prosecuting
24 authorities determine that there is insufficient
25 evidence of fraud or willful misrepresentation by the
26 provider or alternate payee.

1 (2) Legal proceedings related to the provider's or
2 alternate payee's alleged fraud, willful
3 misrepresentation, violations of this Act, or
4 violations of the Illinois Department's administrative
5 rules are completed.

6 (3) The withholding of payments for a period of 3
7 years.

8 (c) The Illinois Department may adopt all rules
9 necessary to implement this subsection (K).

10 (K-5) The Illinois Department may withhold payments, in
11 whole or in part, to a provider or alternate payee upon
12 initiation of an audit, quality of care review, investigation
13 when there is a credible allegation of fraud, or the provider
14 or alternate payee demonstrating a clear failure to cooperate
15 with the Illinois Department such that the circumstances give
16 rise to the need for a withholding of payments. As used in this
17 subsection, "credible allegation" is defined to include an
18 allegation from any source, including, but not limited to,
19 fraud hotline complaints, claims data mining, patterns
20 identified through provider audits, civil actions filed under
21 the False Claims Act, and law enforcement investigations. An
22 allegation is considered to be credible when it has indicia of
23 reliability. The Illinois Department may withhold payments
24 without first notifying the provider or alternate payee of its
25 intention to withhold such payments. A provider or alternate
26 payee may request a hearing or a reconsideration of payment

1 withholding, and the Illinois Department must grant such a
2 request. The Illinois Department shall state by rule a process
3 and criteria by which a provider or alternate payee may request
4 a hearing or a reconsideration for the full or partial release
5 of payments withheld under this subsection. This request may be
6 made at any time after the Illinois Department first withholds
7 such payments.

8 (a) The Illinois Department must send notice of its
9 withholding of program payments within 5 days of taking
10 such action. The notice must set forth the general
11 allegations as to the nature of the withholding action but
12 need not disclose any specific information concerning its
13 ongoing investigation. The notice must do all of the
14 following:

15 (1) State that payments are being withheld in
16 accordance with this subsection.

17 (2) State that the withholding is for a temporary
18 period, as stated in paragraph (b) of this subsection,
19 and cite the circumstances under which withholding
20 will be terminated.

21 (3) Specify, when appropriate, which type or types
22 of claims are withheld.

23 (4) Inform the provider or alternate payee of the
24 right to request a hearing or a reconsideration of the
25 withholding by the Illinois Department, including the
26 ability to submit written evidence.

1 (5) Inform the provider or alternate payee that a
2 written request may be made to the Illinois Department
3 for a hearing or a reconsideration for the full or
4 partial release of withheld payments and that such
5 requests may be made at any time after the Illinois
6 Department first withholds such payments.

7 (b) All withholding of payment actions under this
8 subsection shall be temporary and shall not continue after
9 any of the following:

10 (1) The Illinois Department determines that there
11 is insufficient evidence of fraud, or the provider or
12 alternate payee demonstrates clear cooperation with
13 the Illinois Department, as determined by the Illinois
14 Department, such that the circumstances do not give
15 rise to the need for withholding of payments; or

16 (2) The withholding of payments has lasted for a
17 period in excess of 3 years.

18 (c) The Illinois Department may adopt all rules
19 necessary to implement this subsection (K-5).

20 (L) The Illinois Department shall establish a protocol to
21 enable health care providers to disclose an actual or potential
22 violation of this Section pursuant to a self-referral
23 disclosure protocol, referred to in this subsection as "the
24 protocol". The protocol shall include direction for health care
25 providers on a specific person, official, or office to whom
26 such disclosures shall be made. The Illinois Department shall

1 post information on the protocol on the Illinois Department's
2 public website. The Illinois Department may adopt rules
3 necessary to implement this subsection (L). In addition to
4 other factors that the Illinois Department finds appropriate,
5 the Illinois Department may consider a health care provider's
6 timely use or failure to use the protocol in considering the
7 provider's failure to comply with this Code.

8 (M) Notwithstanding any other provision of this Code, the
9 Illinois Department, at its discretion, may exempt an entity
10 licensed under the Nursing Home Care Act and the ID/DD
11 Community Care Act from the provisions of subsections (A-15),
12 (B), and (C) of this Section if the licensed entity is in
13 receivership.

14 (Source: P.A. 94-265, eff. 1-1-06; 94-975, eff. 6-30-06.)

15 (305 ILCS 5/12-4.38)

16 Sec. 12-4.38. Special FamilyCare provisions. ~~(a)~~ The
17 Department of Healthcare and Family Services may submit to the
18 Comptroller, and the Comptroller is authorized to pay, on
19 behalf of persons enrolled in the FamilyCare Program, claims
20 for services rendered to an enrollee during the period
21 beginning October 1, 2007, and ending on the effective date of
22 any rules adopted to implement the provisions of this
23 amendatory Act of the 96th General Assembly. The authorization
24 for payment of claims applies only to bona fide claims for
25 payment for services rendered. Any claim for payment which is

1 authorized pursuant to the provisions of this amendatory Act of
2 the 96th General Assembly must adhere to all other applicable
3 rules, regulations, and requirements.

4 ~~(b) Each person enrolled in the FamilyCare Program as of~~
5 ~~the effective date of this amendatory Act of the 96th General~~
6 ~~Assembly whose income exceeds 185% of the Federal Poverty~~
7 ~~Level, but is not more than 400% of the Federal Poverty Level,~~
8 ~~may remain enrolled in the FamilyCare Program pursuant to this~~
9 ~~subsection so long as that person continues to meet the~~
10 ~~eligibility criteria established under the emergency rule at 89~~
11 ~~Ill. Adm. Code 120 (Illinois Register Volume 31, page 15854)~~
12 ~~filed November 7, 2007. In no case may a person continue to be~~
13 ~~enrolled in the FamilyCare Program pursuant to this subsection~~
14 ~~if the person's income rises above 400% of the Federal Poverty~~
15 ~~Level or falls below 185% of the Federal Poverty Level at any~~
16 ~~subsequent time. Nothing contained in this subsection shall~~
17 ~~prevent an individual from enrolling in the FamilyCare Program~~
18 ~~as authorized by paragraph 15 of Section 5-2 of this Code if he~~
19 ~~or she otherwise qualifies under that Section.~~

20 ~~(c) In implementing the provisions of this amendatory Act~~
21 ~~of the 96th General Assembly, the Department of Healthcare and~~
22 ~~Family Services is authorized to adopt only those rules~~
23 ~~necessary, including emergency rules. Nothing in this~~
24 ~~amendatory Act of the 96th General Assembly permits the~~
25 ~~Department to adopt rules or issue a decision that expands~~
26 ~~eligibility for the FamilyCare Program to a person whose income~~

1 ~~exceeds 185% of the Federal Poverty Level as determined from~~
2 ~~time to time by the U.S. Department of Health and Human~~
3 ~~Services, unless the Department is provided with express~~
4 ~~statutory authority.~~

5 (Source: P.A. 96-20, eff. 6-30-09.)

6 (305 ILCS 5/12-4.39)

7 Sec. 12-4.39. Dental clinic grant program.

8 (a) Grant program. On and after July 1, 2012, and subject
9 ~~Subject~~ to funding availability, the Department of Healthcare
10 and Family Services may ~~shall~~ administer a grant program. The
11 purpose of this grant program shall be to build the public
12 infrastructure for dental care and to make grants to local
13 health departments, federally qualified health clinics
14 (FQHCs), and rural health clinics (RHCs) for development of
15 comprehensive dental clinics for dental care services. The
16 primary purpose of these new dental clinics will be to increase
17 dental access for low-income and Department of Healthcare and
18 Family Services clients who have no dental arrangements with a
19 dental provider in a project's service area. The dental clinic
20 must be willing to accept out-of-area clients who need dental
21 services, including emergency services for adults and Early and
22 Periodic Screening, Diagnosis and Treatment (EPSDT)-referral
23 children. Medically Underserved Areas (MUAs) and Health
24 Professional Shortage Areas (HPSAs) shall receive special
25 priority for grants under this program.

1 (b) Eligible applicants. The following entities are
2 eligible to apply for grants:

3 (1) Local health departments.

4 (2) Federally Qualified Health Centers (FQHCs).

5 (3) Rural health clinics (RHCs).

6 (c) Use of grant moneys. Grant moneys must be used to
7 support projects that develop dental services to meet the
8 dental health care needs of Department of Healthcare and Family
9 Services Dental Program clients. Grant moneys must be used for
10 operating expenses, including, but not limited to: insurance;
11 dental supplies and equipment; dental support services; and
12 renovation expenses. Grant moneys may not be used to offset
13 existing indebtedness, supplant existing funds, purchase real
14 property, or pay for personnel service salaries for dental
15 employees.

16 (d) Application process. The Department shall establish
17 procedures for applying for dental clinic grants.

18 (Source: P.A. 96-67, eff. 7-23-09; 96-1000, eff. 7-2-10.)

19 (305 ILCS 5/12-10.5)

20 Sec. 12-10.5. Medical Special Purposes Trust Fund.

21 (a) The Medical Special Purposes Trust Fund ("the Fund") is
22 created. Any grant, gift, donation, or legacy of money or
23 securities that the Department of Healthcare and Family
24 Services is authorized to receive under Section 12-4.18 or
25 Section 12-4.19 or any monies from any other source, and that

1 are ~~is~~ dedicated for functions connected with the
2 administration of any medical program administered by the
3 Department, shall be deposited into the Fund. All federal
4 moneys received by the Department as reimbursement for
5 disbursements authorized to be made from the Fund shall also be
6 deposited into the Fund. In addition, federal moneys received
7 on account of State expenditures made in connection with
8 obtaining compliance with the federal Health Insurance
9 Portability and Accountability Act (HIPAA) shall be deposited
10 into the Fund.

11 (b) No moneys received from a service provider or a
12 governmental or private entity that is enrolled with the
13 Department as a provider of medical services shall be deposited
14 into the Fund.

15 (c) Disbursements may be made from the Fund for the
16 purposes connected with the grants, gifts, donations, ~~or~~
17 legacies, or other monies deposited into the Fund, including,
18 but not limited to, medical quality assessment projects,
19 eligibility population studies, medical information systems
20 evaluations, and other administrative functions that assist
21 the Department in fulfilling its health care mission under any
22 medical program administered by the Department.

23 (Source: P.A. 97-48, eff. 6-28-11.)

24 (305 ILCS 5/12-13.1)

25 Sec. 12-13.1. Inspector General.

1 (a) The Governor shall appoint, and the Senate shall
2 confirm, an Inspector General who shall function within the
3 Illinois Department of Public Aid (now Healthcare and Family
4 Services) and report to the Governor. The term of the Inspector
5 General shall expire on the third Monday of January, 1997 and
6 every 4 years thereafter.

7 (b) In order to prevent, detect, and eliminate fraud,
8 waste, abuse, mismanagement, and misconduct, the Inspector
9 General shall oversee the Department of Healthcare and Family
10 Services' integrity functions, which include, but are not
11 limited to, the following:

12 (1) Investigation of misconduct by employees, vendors,
13 contractors and medical providers, except for allegations
14 of violations of the State Officials and Employees Ethics
15 Act which shall be referred to the Office of the Governor's
16 Executive Inspector General for investigation.

17 (2) Prepayment and post-payment audits ~~Audits~~ of
18 medical providers related to ensuring that appropriate
19 payments are made for services rendered and to the
20 prevention and recovery of overpayments.

21 (3) Monitoring of quality assurance programs
22 administered by the Department of Healthcare and Family
23 Services ~~generally related to the medical assistance~~
24 ~~program and specifically related to any managed care~~
25 ~~program.~~

26 (4) Quality control measurements of the programs

1 administered by the Department of Healthcare and Family
2 Services.

3 (5) Investigations of fraud or intentional program
4 violations committed by clients of the Department of
5 Healthcare and Family Services.

6 (6) Actions initiated against contractors, vendors, or
7 medical providers for any of the following reasons:

8 (A) Violations of the medical assistance program.

9 (B) Sanctions against providers brought in
10 conjunction with the Department of Public Health or the
11 Department of Human Services (as successor to the
12 Department of Mental Health and Developmental
13 Disabilities).

14 (C) Recoveries of assessments against hospitals
15 and long-term care facilities.

16 (D) Sanctions mandated by the United States
17 Department of Health and Human Services against
18 medical providers.

19 (E) Violations of contracts related to any
20 programs administered by the Department of Healthcare
21 and Family Services ~~managed care programs~~.

22 (7) Representation of the Department of Healthcare and
23 Family Services at hearings with the Illinois Department of
24 Financial and Professional Regulation in actions taken
25 against professional licenses held by persons who are in
26 violation of orders for child support payments.

1 (b-5) At the request of the Secretary of Human Services,
2 the Inspector General shall, in relation to any function
3 performed by the Department of Human Services as successor to
4 the Department of Public Aid, exercise one or more of the
5 powers provided under this Section as if those powers related
6 to the Department of Human Services; in such matters, the
7 Inspector General shall report his or her findings to the
8 Secretary of Human Services.

9 (c) Notwithstanding, and in addition to, any other
10 provision of law, the ~~The~~ Inspector General shall have access
11 to all information, personnel and facilities of the Department
12 of Healthcare and Family Services and the Department of Human
13 Services (as successor to the Department of Public Aid), their
14 employees, vendors, contractors and medical providers and any
15 federal, State or local governmental agency that are necessary
16 to perform the duties of the Office as directly related to
17 public assistance programs administered by those departments.
18 No medical provider shall be compelled, however, to provide
19 individual medical records of patients who are not clients of
20 the programs administered by the Department of Healthcare and
21 Family Services ~~Medical Assistance Program~~. State and local
22 governmental agencies are authorized and directed to provide
23 the requested information, assistance or cooperation.

24 For purposes of enhanced program integrity functions and
25 oversight, and to the extent consistent with applicable
26 information and privacy, security, and disclosure laws, State

1 agencies and departments shall provide the Office of Inspector
2 General access to confidential and other information and data,
3 and the Inspector General is authorized to enter into
4 agreements with appropriate federal agencies and departments
5 to secure similar data. This includes, but is not limited to,
6 information pertaining to: licensure; certification; earnings;
7 immigration status; citizenship; wage reporting; unearned and
8 earned income; pension income; employment; supplemental
9 security income; social security numbers; National Provider
10 Identifier (NPI) numbers; the National Practitioner Data Bank
11 (NPDB); program and agency exclusions; taxpayer identification
12 numbers; tax delinquency; corporate information; and death
13 records.

14 The Inspector General shall enter into agreements with
15 State agencies and departments, and is authorized to enter into
16 agreements with federal agencies and departments, under which
17 such agencies and departments shall share data necessary for
18 medical assistance program integrity functions and oversight.
19 The Inspector General shall enter into agreements with State
20 agencies and departments, and is authorized to enter into
21 agreements with federal agencies and departments, under which
22 such agencies shall share data necessary for recipient and
23 vendor screening, review, and investigation, including but not
24 limited to vendor payment and recipient eligibility
25 verification. The Inspector General shall develop, in
26 cooperation with other State and federal agencies and

1 departments, and in compliance with applicable federal laws and
2 regulations, appropriate and effective methods to share such
3 data. The Inspector General shall enter into agreements with
4 State agencies and departments, and is authorized to enter into
5 agreements with federal agencies and departments, including,
6 but not limited to: the Secretary of State; the Department of
7 Revenue; the Department of Public Health; the Department of
8 Human Services; and the Department of Financial and
9 Professional Regulation.

10 The Inspector General shall have the authority to deny
11 payment, prevent overpayments, and recover overpayments.

12 The Inspector General shall have the authority to deny or
13 suspend payment to, and deny, terminate, or suspend the
14 eligibility of, any vendor who fails to grant the Inspector
15 General timely access to full and complete records, including
16 records of recipients under the medical assistance program for
17 the most recent 6 years, in accordance with Section 140.28 of
18 Title 89 of the Illinois Administrative Code, and other
19 information for the purpose of audits, investigations, or other
20 program integrity functions, after reasonable written request
21 by the Inspector General.

22 (d) The Inspector General shall serve as the Department of
23 Healthcare and Family Services' primary liaison with law
24 enforcement, investigatory and prosecutorial agencies,
25 including but not limited to the following:

26 (1) The Department of State Police.

1 (2) The Federal Bureau of Investigation and other
2 federal law enforcement agencies.

3 (3) The various Inspectors General of federal agencies
4 overseeing the programs administered by the Department of
5 Healthcare and Family Services.

6 (4) The various Inspectors General of any other State
7 agencies with responsibilities for portions of programs
8 primarily administered by the Department of Healthcare and
9 Family Services.

10 (5) The Offices of the several United States Attorneys
11 in Illinois.

12 (6) The several State's Attorneys.

13 (7) The offices of the Centers for Medicare and
14 Medicaid Services that administer the Medicare and
15 Medicaid integrity programs.

16 The Inspector General shall meet on a regular basis with
17 these entities to share information regarding possible
18 misconduct by any persons or entities involved with the public
19 aid programs administered by the Department of Healthcare and
20 Family Services.

21 (e) All investigations conducted by the Inspector General
22 shall be conducted in a manner that ensures the preservation of
23 evidence for use in criminal prosecutions. If the Inspector
24 General determines that a possible criminal act relating to
25 fraud in the provision or administration of the medical
26 assistance program has been committed, the Inspector General

1 shall immediately notify the Medicaid Fraud Control Unit. If
2 the Inspector General determines that a possible criminal act
3 has been committed within the jurisdiction of the Office, the
4 Inspector General may request the special expertise of the
5 Department of State Police. The Inspector General may present
6 for prosecution the findings of any criminal investigation to
7 the Office of the Attorney General, the Offices of the several
8 United States Attorneys in Illinois or the several State's
9 Attorneys.

10 (f) To carry out his or her duties as described in this
11 Section, the Inspector General and his or her designees shall
12 have the power to compel by subpoena the attendance and
13 testimony of witnesses and the production of books, electronic
14 records and papers as directly related to public assistance
15 programs administered by the Department of Healthcare and
16 Family Services or the Department of Human Services (as
17 successor to the Department of Public Aid). No medical provider
18 shall be compelled, however, to provide individual medical
19 records of patients who are not clients of the Medical
20 Assistance Program.

21 (g) The Inspector General shall report all convictions,
22 terminations, and suspensions taken against vendors,
23 contractors and medical providers to the Department of
24 Healthcare and Family Services and to any agency responsible
25 for licensing or regulating those persons or entities.

26 (h) The Inspector General shall make annual reports,

1 findings, and recommendations regarding the Office's
2 investigations into reports of fraud, waste, abuse,
3 mismanagement, or misconduct relating to any ~~public aid~~
4 programs administered by the Department of Healthcare and
5 Family Services or the Department of Human Services (as
6 successor to the Department of Public Aid) to the General
7 Assembly and the Governor. These reports shall include, but not
8 be limited to, the following information:

9 (1) Aggregate provider billing and payment
10 information, including the number of providers at various
11 Medicaid earning levels.

12 (2) The number of audits of the medical assistance
13 program and the dollar savings resulting from those audits.

14 (3) The number of prescriptions rejected annually
15 under the Department of Healthcare and Family Services'
16 Refill Too Soon program and the dollar savings resulting
17 from that program.

18 (4) Provider sanctions, in the aggregate, including
19 terminations and suspensions.

20 (5) A detailed summary of the investigations
21 undertaken in the previous fiscal year. These summaries
22 shall comply with all laws and rules regarding maintaining
23 confidentiality in the public aid programs.

24 (i) Nothing in this Section shall limit investigations by
25 the Department of Healthcare and Family Services or the
26 Department of Human Services that may otherwise be required by

1 law or that may be necessary in their capacity as the central
2 administrative authorities responsible for administration of
3 their agency's ~~public aid~~ programs in this State.

4 (j) The Inspector General may issue shields or other
5 distinctive identification to his or her employees not
6 exercising the powers of a peace officer if the Inspector
7 General determines that a shield or distinctive identification
8 is needed by an employee to carry out his or her
9 responsibilities.

10 (Source: P.A. 95-331, eff. 8-21-07; 96-555, eff. 8-18-09;
11 96-1316, eff. 1-1-11.)

12 (305 ILCS 5/14-8) (from Ch. 23, par. 14-8)

13 Sec. 14-8. Disbursements to Hospitals.

14 (a) For inpatient hospital services rendered on and after
15 September 1, 1991, the Illinois Department shall reimburse
16 hospitals for inpatient services at an inpatient payment rate
17 calculated for each hospital based upon the Medicare
18 Prospective Payment System as set forth in Sections 1886(b),
19 (d), (g), and (h) of the federal Social Security Act, and the
20 regulations, policies, and procedures promulgated thereunder,
21 except as modified by this Section. Payment rates for inpatient
22 hospital services rendered on or after September 1, 1991 and on
23 or before September 30, 1992 shall be calculated using the
24 Medicare Prospective Payment rates in effect on September 1,
25 1991. Payment rates for inpatient hospital services rendered on

1 or after October 1, 1992 and on or before March 31, 1994 shall
2 be calculated using the Medicare Prospective Payment rates in
3 effect on September 1, 1992. Payment rates for inpatient
4 hospital services rendered on or after April 1, 1994 shall be
5 calculated using the Medicare Prospective Payment rates
6 (including the Medicare grouping methodology and weighting
7 factors as adjusted pursuant to paragraph (1) of this
8 subsection) in effect 90 days prior to the date of admission.
9 For services rendered on or after July 1, 1995, the
10 reimbursement methodology implemented under this subsection
11 shall not include those costs referred to in Sections
12 1886(d)(5)(B) and 1886(h) of the Social Security Act. The
13 additional payment amounts required under Section
14 1886(d)(5)(F) of the Social Security Act, for hospitals serving
15 a disproportionate share of low-income or indigent patients,
16 are not required under this Section. For hospital inpatient
17 services rendered on or after July 1, 1995, the Illinois
18 Department shall reimburse hospitals using the relative
19 weighting factors and the base payment rates calculated for
20 each hospital that were in effect on June 30, 1995, less the
21 portion of such rates attributed by the Illinois Department to
22 the cost of medical education.

23 (1) The weighting factors established under Section
24 1886(d)(4) of the Social Security Act shall not be used in
25 the reimbursement system established under this Section.
26 Rather, the Illinois Department shall establish by rule

1 Medicaid weighting factors to be used in the reimbursement
2 system established under this Section.

3 (2) The Illinois Department shall define by rule those
4 hospitals or distinct parts of hospitals that shall be
5 exempt from the reimbursement system established under
6 this Section. In defining such hospitals, the Illinois
7 Department shall take into consideration those hospitals
8 exempt from the Medicare Prospective Payment System as of
9 September 1, 1991. For hospitals defined as exempt under
10 this subsection, the Illinois Department shall by rule
11 establish a reimbursement system for payment of inpatient
12 hospital services rendered on and after September 1, 1991.
13 For all hospitals that are children's hospitals as defined
14 in Section 5-5.02 of this Code, the reimbursement
15 methodology shall, through June 30, 1992, net of all
16 applicable fees, at least equal each children's hospital
17 1990 ICARE payment rates, indexed to the current year by
18 application of the DRI hospital cost index from 1989 to the
19 year in which payments are made. Excepting county providers
20 as defined in Article XV of this Code, hospitals licensed
21 under the University of Illinois Hospital Act, and
22 facilities operated by the Department of Mental Health and
23 Developmental Disabilities (or its successor, the
24 Department of Human Services) for hospital inpatient
25 services rendered on or after July 1, 1995, the Illinois
26 Department shall reimburse children's hospitals, as

1 defined in 89 Illinois Administrative Code Section
2 149.50(c)(3), at the rates in effect on June 30, 1995, and
3 shall reimburse all other hospitals at the rates in effect
4 on June 30, 1995, less the portion of such rates attributed
5 by the Illinois Department to the cost of medical
6 education. For inpatient hospital services provided on or
7 after August 1, 1998, the Illinois Department may establish
8 by rule a means of adjusting the rates of children's
9 hospitals, as defined in 89 Illinois Administrative Code
10 Section 149.50(c)(3), that did not meet that definition on
11 June 30, 1995, in order for the inpatient hospital rates of
12 such hospitals to take into account the average inpatient
13 hospital rates of those children's hospitals that did meet
14 the definition of children's hospitals on June 30, 1995.

15 (3) (Blank)

16 (4) Notwithstanding any other provision of this
17 Section, hospitals that on August 31, 1991, have a contract
18 with the Illinois Department under Section 3-4 of the
19 Illinois Health Finance Reform Act may elect to continue to
20 be reimbursed at rates stated in such contracts for general
21 and specialty care.

22 (5) In addition to any payments made under this
23 subsection (a), the Illinois Department shall make the
24 adjustment payments required by Section 5-5.02 of this
25 Code; provided, that in the case of any hospital reimbursed
26 under a per case methodology, the Illinois Department shall

1 add an amount equal to the product of the hospital's
2 average length of stay, less one day, multiplied by 20, for
3 inpatient hospital services rendered on or after September
4 1, 1991 and on or before September 30, 1992.

5 (b) (Blank)

6 (b-5) Excepting county providers as defined in Article XV
7 of this Code, hospitals licensed under the University of
8 Illinois Hospital Act, and facilities operated by the Illinois
9 Department of Mental Health and Developmental Disabilities (or
10 its successor, the Department of Human Services), for
11 outpatient services rendered on or after July 1, 1995 and
12 before July 1, 1998 the Illinois Department shall reimburse
13 children's hospitals, as defined in the Illinois
14 Administrative Code Section 149.50(c)(3), at the rates in
15 effect on June 30, 1995, less that portion of such rates
16 attributed by the Illinois Department to the outpatient
17 indigent volume adjustment and shall reimburse all other
18 hospitals at the rates in effect on June 30, 1995, less the
19 portions of such rates attributed by the Illinois Department to
20 the cost of medical education and attributed by the Illinois
21 Department to the outpatient indigent volume adjustment. For
22 outpatient services provided on or after July 1, 1998,
23 reimbursement rates shall be established by rule.

24 (c) In addition to any other payments under this Code, the
25 Illinois Department shall develop a hospital disproportionate
26 share reimbursement methodology that, effective July 1, 1991,

1 through September 30, 1992, shall reimburse hospitals
2 sufficiently to expend the fee monies described in subsection
3 (b) of Section 14-3 of this Code and the federal matching funds
4 received by the Illinois Department as a result of expenditures
5 made by the Illinois Department as required by this subsection
6 (c) and Section 14-2 that are attributable to fee monies
7 deposited in the Fund, less amounts applied to adjustment
8 payments under Section 5-5.02.

9 (d) Critical Care Access Payments.

10 (1) In addition to any other payments made under this
11 Code, the Illinois Department shall develop a
12 reimbursement methodology that shall reimburse Critical
13 Care Access Hospitals for the specialized services that
14 qualify them as Critical Care Access Hospitals. No
15 adjustment payments shall be made under this subsection on
16 or after July 1, 1995.

17 (2) "Critical Care Access Hospitals" includes, but is
18 not limited to, hospitals that meet at least one of the
19 following criteria:

20 (A) Hospitals located outside of a metropolitan
21 statistical area that are designated as Level II
22 Perinatal Centers and that provide a disproportionate
23 share of perinatal services to recipients; or

24 (B) Hospitals that are designated as Level I Trauma
25 Centers (adult or pediatric) and certain Level II
26 Trauma Centers as determined by the Illinois

1 Department; or

2 (C) Hospitals located outside of a metropolitan
3 statistical area and that provide a disproportionate
4 share of obstetrical services to recipients.

5 (e) Inpatient high volume adjustment. For hospital
6 inpatient services, effective with rate periods beginning on or
7 after October 1, 1993, in addition to rates paid for inpatient
8 services by the Illinois Department, the Illinois Department
9 shall make adjustment payments for inpatient services
10 furnished by Medicaid high volume hospitals. The Illinois
11 Department shall establish by rule criteria for qualifying as a
12 Medicaid high volume hospital and shall establish by rule a
13 reimbursement methodology for calculating these adjustment
14 payments to Medicaid high volume hospitals. No adjustment
15 payment shall be made under this subsection for services
16 rendered on or after July 1, 1995.

17 (f) The Illinois Department shall modify its current rules
18 governing adjustment payments for targeted access, critical
19 care access, and uncompensated care to classify those
20 adjustment payments as not being payments to disproportionate
21 share hospitals under Title XIX of the federal Social Security
22 Act. Rules adopted under this subsection shall not be effective
23 with respect to services rendered on or after July 1, 1995. The
24 Illinois Department has no obligation to adopt or implement any
25 rules or make any payments under this subsection for services
26 rendered on or after July 1, 1995.

1 (f-5) The State recognizes that adjustment payments to
2 hospitals providing certain services or incurring certain
3 costs may be necessary to assure that recipients of medical
4 assistance have adequate access to necessary medical services.
5 These adjustments include payments for teaching costs and
6 uncompensated care, trauma center payments, rehabilitation
7 hospital payments, perinatal center payments, obstetrical care
8 payments, targeted access payments, Medicaid high volume
9 payments, and outpatient indigent volume payments. On or before
10 April 1, 1995, the Illinois Department shall issue
11 recommendations regarding (i) reimbursement mechanisms or
12 adjustment payments to reflect these costs and services,
13 including methods by which the payments may be calculated and
14 the method by which the payments may be financed, and (ii)
15 reimbursement mechanisms or adjustment payments to reflect
16 costs and services of federally qualified health centers with
17 respect to recipients of medical assistance.

18 (g) If one or more hospitals file suit in any court
19 challenging any part of this Article XIV, payments to hospitals
20 under this Article XIV shall be made only to the extent that
21 sufficient monies are available in the Fund and only to the
22 extent that any monies in the Fund are not prohibited from
23 disbursement under any order of the court.

24 (h) Payments under the disbursement methodology described
25 in this Section are subject to approval by the federal
26 government in an appropriate State plan amendment.

1 (i) The Illinois Department may by rule establish criteria
2 for and develop methodologies for adjustment payments to
3 hospitals participating under this Article.

4 (j) Hospital Residing Long Term Care Services. In addition
5 to any other payments made under this Code, the Illinois
6 Department may by rule establish criteria and develop
7 methodologies for payments to hospitals for Hospital Residing
8 Long Term Care Services.

9 (k) Critical Access Hospital outpatient payments. In
10 addition to any other payments authorized under this Code, the
11 Illinois Department shall reimburse critical access hospitals,
12 as designated by the Illinois Department of Public Health in
13 accordance with 42 CFR 485, Subpart F, for outpatient services
14 at an amount that is no less than the cost of providing such
15 services, based on Medicare cost principles. Payments under
16 this subsection shall be subject to appropriation.

17 (l) 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. 96-1382, eff. 1-1-11.)

23 (305 ILCS 5/14-11 new)

24 Sec. 14-11. Hospital payment reform.

25 (a) The Department may, by rule, implement the All Patient

1 Refined Diagnosis Related Groups (APR-DRG) payment system for
2 inpatient services provided on or after July 1, 2013, in a
3 manner consistent with the actions authorized in this Section.

4 (b) On or before October 1, 2012 and through June 30, 2013,
5 the Department shall begin testing the APR-DRG system. During
6 the testing period the Department shall process and price
7 inpatient services using the APR-DRG system; however, actual
8 payments for those inpatient services shall be made using the
9 current reimbursement system. During the testing period, the
10 Department, in collaboration with the statewide representative
11 of hospitals, shall provide information and technical
12 assistance to hospitals to encourage and facilitate their
13 transition to the APR-DRG system.

14 (c) The Department may, by rule, implement the Enhanced
15 Ambulatory Procedure Grouping (EAPG) system for outpatient
16 services provided on or after January 1, 2014, in a manner
17 consistent with the actions authorized in this Section. On or
18 before January 1, 2013 and through December 31, 2013, the
19 Department shall begin testing the EAPG system. During the
20 testing period the Department shall process and price
21 outpatient services using the EAPG system; however, actual
22 payments for those outpatient services shall be made using the
23 current reimbursement system. During the testing period, the
24 Department, in collaboration with the statewide representative
25 of hospitals, shall provide information and technical
26 assistance to hospitals to encourage and facilitate their

1 transition to the EAPG system.

2 (d) The Department in consultation with the current
3 hospital technical advisory group shall review the test claims
4 for inpatient and outpatient services at least monthly,
5 including the estimated impact on hospitals, and, in developing
6 the rules, policies, and procedures to implement the new
7 payment systems, shall consider at least the following issues:

8 (1) The use of national relative weights provided by
9 the vendor of the APR-DRG system, adjusted to reflect
10 characteristics of the Illinois Medical Assistance
11 population.

12 (2) An updated outlier payment methodology based on
13 current data and consistent with the APR-DRG system.

14 (3) The use of policy adjusters to enhance payments to
15 hospitals treating a high percentage of individuals
16 covered by the Medical Assistance program and uninsured
17 patients.

18 (4) Reimbursement for inpatient specialty services
19 such as psychiatric, rehabilitation, and long-term acute
20 care using updated per diem rates that account for service
21 acuity.

22 (5) The creation of one or more transition funding
23 pools to preserve access to care and to ensure financial
24 stability as hospitals transition to the new payment
25 system.

26 (6) Whether, beginning July 1, 2014, some of the static

1 adjustment payments financed by General Revenue funds
2 should be used as part of the base payment system,
3 including as policy adjusters to recognize the additional
4 costs of certain services, such as pediatric or neonatal,
5 or providers, such as trauma centers, Critical Access
6 Hospitals, or high Medicaid hospitals, or for services to
7 uninsured patients.

8 (e) The Department shall provide the association
9 representing the majority of hospitals in Illinois, as the
10 statewide representative of the hospital community, with a
11 monthly file of claims adjudicated under the test system for
12 the purpose of review and analysis as part of the collaboration
13 between the State and the hospital community. The file shall
14 consist of a de-identified extract compliant with the Health
15 Insurance Portability and Accountability Act (HIPAA).

16 (f) The current hospital technical advisory group shall
17 make recommendations for changes during the testing period and
18 recommendations for changes prior to the effective dates of the
19 new payment systems. The Department shall draft administrative
20 rules to implement the new payment systems and provide them to
21 the technical advisory group at least 90 days prior to the
22 proposed effective dates of the new payment systems.

23 (g) The payments to hospitals financed by the current
24 hospital assessment, authorized under Article V-A of this Code,
25 are scheduled to sunset on June 30, 2014. The continuation of
26 or revisions to the hospital assessment program shall take into

1 consideration the impact on hospitals and access to care as a
2 result of the changes to the hospital payment system.

3 (h) Beginning July 1, 2014, the Department may transition
4 current General Revenue funded supplemental payments into the
5 claims based system over a period of no less than 2 years from
6 the implementation date of the new payment systems and no more
7 than 4 years from the implementation date of the new payment
8 systems, provided however that the Department may adopt, by
9 rule, supplemental payments to help ensure access to care in a
10 geographic area or to help ensure access to specialty services.
11 For any supplemental payments that are adopted that are based
12 on historic data, the data shall be no older than 3 years and
13 the supplemental payment shall be effective for no longer than
14 2 years before requiring the data to be updated.

15 (i) Any payments authorized under 89 Illinois
16 Administrative Code 148 set to expire in State fiscal year 2012
17 and that were paid out to hospitals in State fiscal year 2012
18 shall remain in effect as long as the assessment imposed by
19 Section 5A-2 is in effect.

20 (j) Subsections (a) and (c) of this Section shall remain
21 operative unless the Auditor General has reported that: (i) the
22 Department has not undertaken the required actions listed in
23 the report required by subsection (a) of Section 2-20 of the
24 Illinois State Auditing Act; or (ii) the Department has failed
25 to comply with the reporting requirements of Section 2-20 of
26 the Illinois State Auditing Act.

1 (k) Subsections (a) and (c) of this Section shall not be
2 operative until final federal approval by the Centers for
3 Medicare and Medicaid Services of the U.S. Department of Health
4 and Human Services and implementation of all of the payments
5 and assessments in Article V-A in its form as of the effective
6 date of this amendatory Act of the 97th General Assembly or as
7 it may be amended.

8 (305 ILCS 5/15-1) (from Ch. 23, par. 15-1)

9 Sec. 15-1. Definitions. As used in this Article, unless the
10 context requires otherwise:

11 (a) (Blank). ~~"Base amount" means \$109,800,000 multiplied~~
12 ~~by a fraction, the numerator of which is the number of days~~
13 ~~represented by the payments in question and the denominator of~~
14 ~~which is 365.~~

15 (a-5) "County provider" means a health care provider that
16 is, or is operated by, a county with a population greater than
17 3,000,000.

18 (b) "Fund" means the County Provider Trust Fund.

19 (c) "Hospital" or "County hospital" means a hospital, as
20 defined in Section 14-1 of this Code, which is a county
21 hospital located in a county of over 3,000,000 population.

22 (Source: P.A. 87-13; 88-85; 88-554, eff. 7-26-94.)

23 Section 85. The Pediatric Palliative Care Act is amended by
24 adding Section 3 as follows:

1 (305 ILCS 60/3 new)

2 Sec. 3. Act inoperative. Notwithstanding any other
3 provision of law, this Act is inoperative on and after July 1,
4 2012.

5 (305 ILCS 5/5-5.4a rep.)

6 (305 ILCS 5/5-5.4c rep.)

7 (305 ILCS 5/12-4.36 rep.)

8 Section 88. The Illinois Public Aid Code is amended by
9 repealing Sections 5-5.4a, 5-5.4c, and 12-4.36.

10 Section 90. The Senior Citizens and Disabled Persons
11 Property Tax Relief and Pharmaceutical Assistance Act is
12 amended by changing the title of the Act and Sections 1, 1.5,
13 2, 3.05a, 3.10, 4, 4.05, 5, 6, 7, 8, 9, 12, and 13 as follows:

14 (320 ILCS 25/Act title)

15 An Act in relation to the payment of grants to enable the
16 elderly and the disabled to acquire or retain private housing
17 ~~and to acquire prescription drugs.~~

18 (320 ILCS 25/1) (from Ch. 67 1/2, par. 401)

19 Sec. 1. Short title; common name. This Article shall be
20 known and may be cited as the Senior Citizens and Disabled
21 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.

1 Common references to the "Circuit Breaker Act" mean this
2 Article. As used in this Article, "this Act" means this
3 Article.

4 (Source: P.A. 96-804, eff. 1-1-10.)

5 (320 ILCS 25/1.5)

6 Sec. 1.5. Implementation of Executive Order No. 3 of 2004;
7 termination of the Illinois Senior Citizens and Disabled
8 Persons Pharmaceutical Assistance Program. Executive Order No.
9 3 of 2004, in part, provided for the transfer of the programs
10 under this Act from the Department of Revenue to the Department
11 on Aging and the Department of Healthcare and Family Services.
12 It is the purpose of this amendatory Act of the 96th General
13 Assembly to conform this Act and certain related provisions of
14 other statutes to that Executive Order. This amendatory Act of
15 the 96th General Assembly also makes other substantive changes
16 to this Act.

17 It is the purpose of this amendatory Act of the 97th
18 General Assembly to terminate the Illinois Senior Citizens and
19 Disabled Persons Pharmaceutical Assistance Program on July 1,
20 2012.

21 (Source: P.A. 96-804, eff. 1-1-10.)

22 (320 ILCS 25/2) (from Ch. 67 1/2, par. 402)

23 Sec. 2. Purpose. The purpose of this Act is to provide
24 incentives to the senior citizens and disabled persons of this

1 State to acquire and retain private housing of their choice and
2 at the same time to relieve those citizens from the burdens of
3 extraordinary property taxes ~~and rising drug costs~~ against
4 their increasingly restricted earning power, and thereby to
5 reduce the requirements for public housing in this State.

6 (Source: P.A. 96-804, eff. 1-1-10.)

7 (320 ILCS 25/3.05a)

8 Sec. 3.05a. Additional resident. "Additional resident"
9 means a person who (i) is living in the same residence with a
10 claimant for the claim year and at the time of filing the
11 claim, (ii) is not the spouse of the claimant, (iii) does not
12 file a separate claim under this Act for the same period, and
13 (iv) receives more than half of his or her total financial
14 support for that claim year from the household. Prior to July
15 1, 2012, an ~~An~~ additional resident who meets qualifications may
16 receive pharmaceutical assistance based on a claimant's
17 application.

18 (Source: P.A. 96-804, eff. 1-1-10.)

19 (320 ILCS 25/3.10) (from Ch. 67 1/2, par. 403.10)

20 Sec. 3.10. Regulations. "Regulations" includes both rules
21 promulgated and forms prescribed by the applicable Department.
22 In this Act, references to the rules of the Department on Aging
23 or the Department of Healthcare and Family Services, in effect
24 prior to July 1, 2012, shall be deemed to include, in

1 appropriate cases, the corresponding rules adopted by the
2 Department of Revenue, to the extent that those rules continue
3 in force under Executive Order No. 3 of 2004.

4 (Source: P.A. 96-804, eff. 1-1-10.)

5 (320 ILCS 25/4) (from Ch. 67 1/2, par. 404)

6 Sec. 4. Amount of Grant.

7 (a) In general. Any individual 65 years or older or any
8 individual who will become 65 years old during the calendar
9 year in which a claim is filed, and any surviving spouse of
10 such a claimant, who at the time of death received or was
11 entitled to receive a grant pursuant to this Section, which
12 surviving spouse will become 65 years of age within the 24
13 months immediately following the death of such claimant and
14 which surviving spouse but for his or her age is otherwise
15 qualified to receive a grant pursuant to this Section, and any
16 disabled person whose annual household income is less than the
17 income eligibility limitation, as defined in subsection (a-5)
18 and whose household is liable for payment of property taxes
19 accrued or has paid rent constituting property taxes accrued
20 and is domiciled in this State at the time he or she files his
21 or her claim is entitled to claim a grant under this Act. With
22 respect to claims filed by individuals who will become 65 years
23 old during the calendar year in which a claim is filed, the
24 amount of any grant to which that household is entitled shall
25 be an amount equal to 1/12 of the amount to which the claimant

1 would otherwise be entitled as provided in this Section,
2 multiplied by the number of months in which the claimant was 65
3 in the calendar year in which the claim is filed.

4 (a-5) Income eligibility limitation. For purposes of this
5 Section, "income eligibility limitation" means an amount for
6 grant years 2008 and thereafter:

7 (1) less than \$22,218 for a household containing one
8 person;

9 (2) less than \$29,480 for a household containing 2
10 persons; or

11 (3) less than \$36,740 for a household containing 3 or
12 more persons.

13 For 2009 claim year applications submitted during calendar
14 year 2010, a household must have annual household income of
15 less than \$27,610 for a household containing one person; less
16 than \$36,635 for a household containing 2 persons; or less than
17 \$45,657 for a household containing 3 or more persons.

18 The Department on Aging may adopt rules such that on
19 January 1, 2011, and thereafter, the foregoing household income
20 eligibility limits may be changed to reflect the annual cost of
21 living adjustment in Social Security and Supplemental Security
22 Income benefits that are applicable to the year for which those
23 benefits are being reported as income on an application.

24 If a person files as a surviving spouse, then only his or
25 her income shall be counted in determining his or her household
26 income.

1 (b) Limitation. Except as otherwise provided in
2 subsections (a) and (f) of this Section, the maximum amount of
3 grant which a claimant is entitled to claim is the amount by
4 which the property taxes accrued which were paid or payable
5 during the last preceding tax year or rent constituting
6 property taxes accrued upon the claimant's residence for the
7 last preceding taxable year exceeds 3 1/2% of the claimant's
8 household income for that year but in no event is the grant to
9 exceed (i) \$700 less 4.5% of household income for that year for
10 those with a household income of \$14,000 or less or (ii) \$70 if
11 household income for that year is more than \$14,000.

12 (c) Public aid recipients. If household income in one or
13 more months during a year includes cash assistance in excess of
14 \$55 per month from the Department of Healthcare and Family
15 Services or the Department of Human Services (acting as
16 successor to the Department of Public Aid under the Department
17 of Human Services Act) which was determined under regulations
18 of that Department on a measure of need that included an
19 allowance for actual rent or property taxes paid by the
20 recipient of that assistance, the amount of grant to which that
21 household is entitled, except as otherwise provided in
22 subsection (a), shall be the product of (1) the maximum amount
23 computed as specified in subsection (b) of this Section and (2)
24 the ratio of the number of months in which household income did
25 not include such cash assistance over \$55 to the number twelve.
26 If household income did not include such cash assistance over

1 \$55 for any months during the year, the amount of the grant to
2 which the household is entitled shall be the maximum amount
3 computed as specified in subsection (b) of this Section. For
4 purposes of this paragraph (c), "cash assistance" does not
5 include any amount received under the federal Supplemental
6 Security Income (SSI) program.

7 (d) Joint ownership. If title to the residence is held
8 jointly by the claimant with a person who is not a member of
9 his or her household, the amount of property taxes accrued used
10 in computing the amount of grant to which he or she is entitled
11 shall be the same percentage of property taxes accrued as is
12 the percentage of ownership held by the claimant in the
13 residence.

14 (e) More than one residence. If a claimant has occupied
15 more than one residence in the taxable year, he or she may
16 claim only one residence for any part of a month. In the case
17 of property taxes accrued, he or she shall prorate 1/12 of the
18 total property taxes accrued on his or her residence to each
19 month that he or she owned and occupied that residence; and, in
20 the case of rent constituting property taxes accrued, shall
21 prorate each month's rent payments to the residence actually
22 occupied during that month.

23 (f) (Blank).

24 (g) Effective January 1, 2006, there is hereby established
25 a program of pharmaceutical assistance to the aged and
26 disabled, entitled the Illinois Seniors and Disabled Drug

1 Coverage Program, which shall be administered by the Department
2 of Healthcare and Family Services and the Department on Aging
3 in accordance with this subsection, to consist of coverage of
4 specified prescription drugs on behalf of beneficiaries of the
5 program as set forth in this subsection. Notwithstanding any
6 provisions of this Act to the contrary, on and after July 1,
7 2012, pharmaceutical assistance under this Act shall no longer
8 be provided, and on July 1, 2012 the Illinois Senior Citizens
9 and Disabled Persons Pharmaceutical Assistance Program shall
10 terminate. The following provisions that concern the Illinois
11 Senior Citizens and Disabled Persons Pharmaceutical Assistance
12 Program shall continue to apply on and after July 1, 2012 to
13 the extent necessary to pursue any actions authorized by
14 subsection (d) of Section 9 of this Act with respect to acts
15 which took place prior to July 1, 2012.

16 To become a beneficiary under the program established under
17 this subsection, a person must:

18 (1) be (i) 65 years of age or older or (ii) disabled;

19 and

20 (2) be domiciled in this State; and

21 (3) enroll with a qualified Medicare Part D
22 Prescription Drug Plan if eligible and apply for all
23 available subsidies under Medicare Part D; and

24 (4) for the 2006 and 2007 claim years, have a maximum
25 household income of (i) less than \$21,218 for a household
26 containing one person, (ii) less than \$28,480 for a

1 household containing 2 persons, or (iii) less than \$35,740
2 for a household containing 3 or more persons; and

3 (5) for the 2008 claim year, have a maximum household
4 income of (i) less than \$22,218 for a household containing
5 one person, (ii) \$29,480 for a household containing 2
6 persons, or (iii) \$36,740 for a household containing 3 or
7 more persons; and

8 (6) for 2009 claim year applications submitted during
9 calendar year 2010, have annual household income of less
10 than (i) \$27,610 for a household containing one person;
11 (ii) less than \$36,635 for a household containing 2
12 persons; or (iii) less than \$45,657 for a household
13 containing 3 or more persons; and

14 (7) as of September 1, 2011, have a maximum household
15 income at or below 200% of the federal poverty level.

16 All individuals enrolled as of December 31, 2005, in the
17 pharmaceutical assistance program operated pursuant to
18 subsection (f) of this Section and all individuals enrolled as
19 of December 31, 2005, in the SeniorCare Medicaid waiver program
20 operated pursuant to Section 5-5.12a of the Illinois Public Aid
21 Code shall be automatically enrolled in the program established
22 by this subsection for the first year of operation without the
23 need for further application, except that they must apply for
24 Medicare Part D and the Low Income Subsidy under Medicare Part
25 D. A person enrolled in the pharmaceutical assistance program
26 operated pursuant to subsection (f) of this Section as of

1 December 31, 2005, shall not lose eligibility in future years
2 due only to the fact that they have not reached the age of 65.

3 To the extent permitted by federal law, the Department may
4 act as an authorized representative of a beneficiary in order
5 to enroll the beneficiary in a Medicare Part D Prescription
6 Drug Plan if the beneficiary has failed to choose a plan and,
7 where possible, to enroll beneficiaries in the low-income
8 subsidy program under Medicare Part D or assist them in
9 enrolling in that program.

10 Beneficiaries under the program established under this
11 subsection shall be divided into the following 4 eligibility
12 groups:

13 (A) Eligibility Group 1 shall consist of beneficiaries
14 who are not eligible for Medicare Part D coverage and who
15 are:

16 (i) disabled and under age 65; or

17 (ii) age 65 or older, with incomes over 200% of the
18 Federal Poverty Level; or

19 (iii) age 65 or older, with incomes at or below
20 200% of the Federal Poverty Level and not eligible for
21 federally funded means-tested benefits due to
22 immigration status.

23 (B) Eligibility Group 2 shall consist of beneficiaries
24 who are eligible for Medicare Part D coverage.

25 (C) Eligibility Group 3 shall consist of beneficiaries
26 age 65 or older, with incomes at or below 200% of the

1 Federal Poverty Level, who are not barred from receiving
2 federally funded means-tested benefits due to immigration
3 status and are not eligible for Medicare Part D coverage.

4 If the State applies and receives federal approval for
5 a waiver under Title XIX of the Social Security Act,
6 persons in Eligibility Group 3 shall continue to receive
7 benefits through the approved waiver, and Eligibility
8 Group 3 may be expanded to include disabled persons under
9 age 65 with incomes under 200% of the Federal Poverty Level
10 who are not eligible for Medicare and who are not barred
11 from receiving federally funded means-tested benefits due
12 to immigration status.

13 (D) Eligibility Group 4 shall consist of beneficiaries
14 who are otherwise described in Eligibility Group 2 who have
15 a diagnosis of HIV or AIDS.

16 The program established under this subsection shall cover
17 the cost of covered prescription drugs in excess of the
18 beneficiary cost-sharing amounts set forth in this paragraph
19 that are not covered by Medicare. The Department of Healthcare
20 and Family Services may establish by emergency rule changes in
21 cost-sharing necessary to conform the cost of the program to
22 the amounts appropriated for State fiscal year 2012 and future
23 fiscal years except that the 24-month limitation on the
24 adoption of emergency rules and the provisions of Sections
25 5-115 and 5-125 of the Illinois Administrative Procedure Act
26 shall not apply to rules adopted under this subsection (g). The

1 adoption of emergency rules authorized by this subsection (g)
2 shall be deemed to be necessary for the public interest,
3 safety, and welfare.

4 For purposes of the program established under this
5 subsection, the term "covered prescription drug" has the
6 following meanings:

7 For Eligibility Group 1, "covered prescription drug"
8 means: (1) any cardiovascular agent or drug; (2) any
9 insulin or other prescription drug used in the treatment of
10 diabetes, including syringe and needles used to administer
11 the insulin; (3) any prescription drug used in the
12 treatment of arthritis; (4) any prescription drug used in
13 the treatment of cancer; (5) any prescription drug used in
14 the treatment of Alzheimer's disease; (6) any prescription
15 drug used in the treatment of Parkinson's disease; (7) any
16 prescription drug used in the treatment of glaucoma; (8)
17 any prescription drug used in the treatment of lung disease
18 and smoking-related illnesses; (9) any prescription drug
19 used in the treatment of osteoporosis; and (10) any
20 prescription drug used in the treatment of multiple
21 sclerosis. The Department may add additional therapeutic
22 classes by rule. The Department may adopt a preferred drug
23 list within any of the classes of drugs described in items
24 (1) through (10) of this paragraph. The specific drugs or
25 therapeutic classes of covered prescription drugs shall be
26 indicated by rule.

1 For Eligibility Group 2, "covered prescription drug"
2 means those drugs covered by the Medicare Part D
3 Prescription Drug Plan in which the beneficiary is
4 enrolled.

5 For Eligibility Group 3, "covered prescription drug"
6 means those drugs covered by the Medical Assistance Program
7 under Article V of the Illinois Public Aid Code.

8 For Eligibility Group 4, "covered prescription drug"
9 means those drugs covered by the Medicare Part D
10 Prescription Drug Plan in which the beneficiary is
11 enrolled.

12 Any person otherwise eligible for pharmaceutical
13 assistance under this subsection whose covered drugs are
14 covered by any public program is ineligible for assistance
15 under this subsection to the extent that the cost of those
16 drugs is covered by the other program.

17 The Department of Healthcare and Family Services shall
18 establish by rule the methods by which it will provide for the
19 coverage called for in this subsection. Those methods may
20 include direct reimbursement to pharmacies or the payment of a
21 capitated amount to Medicare Part D Prescription Drug Plans.

22 For a pharmacy to be reimbursed under the program
23 established under this subsection, it must comply with rules
24 adopted by the Department of Healthcare and Family Services
25 regarding coordination of benefits with Medicare Part D
26 Prescription Drug Plans. A pharmacy may not charge a

1 Medicare-enrolled beneficiary of the program established under
2 this subsection more for a covered prescription drug than the
3 appropriate Medicare cost-sharing less any payment from or on
4 behalf of the Department of Healthcare and Family Services.

5 The Department of Healthcare and Family Services or the
6 Department on Aging, as appropriate, may adopt rules regarding
7 applications, counting of income, proof of Medicare status,
8 mandatory generic policies, and pharmacy reimbursement rates
9 and any other rules necessary for the cost-efficient operation
10 of the program established under this subsection.

11 (h) A qualified individual is not entitled to duplicate
12 benefits in a coverage period as a result of the changes made
13 by this amendatory Act of the 96th General Assembly.

14 (Source: P.A. 96-804, eff. 1-1-10; 97-74, eff. 6-30-11; 97-333,
15 eff. 8-12-11.)

16 (320 ILCS 25/4.05)

17 Sec. 4.05. Application.

18 (a) The Department on Aging shall establish the content,
19 required eligibility and identification information, use of
20 social security numbers, and manner of applying for benefits in
21 a simplified format under this Act, ~~including claims filed for~~
22 ~~new or renewed prescription drug benefits.~~

23 (b) An application may be filed on paper or over the
24 Internet ~~to enable persons to apply separately or for both a~~
25 ~~property tax relief grant and pharmaceutical assistance on the~~

1 ~~same application. An application may also enable persons to~~
2 ~~apply for other State or federal programs that provide medical~~
3 ~~or pharmaceutical assistance or other benefits, as determined~~
4 ~~by the Department on Aging in conjunction with the Department~~
5 ~~of Healthcare and Family Services.~~

6 (c) Applications must be filed during the time period
7 prescribed by the Department.

8 (Source: P.A. 96-804, eff. 1-1-10.)

9 (320 ILCS 25/5) (from Ch. 67 1/2, par. 405)

10 Sec. 5. Procedure.

11 (a) In general. Claims must be filed after January 1, on
12 forms prescribed by the Department. No claim may be filed more
13 than one year after December 31 of the year for which the claim
14 is filed. ~~The pharmaceutical assistance identification card~~
15 ~~provided for in subsection (f) of Section 4 shall be valid for~~
16 ~~a period determined by the Department of Healthcare and Family~~
17 ~~Services.~~

18 (b) Claim is Personal. The right to file a claim under this
19 Act shall be personal to the claimant and shall not survive his
20 death, but such right may be exercised on behalf of a claimant
21 by his legal guardian or attorney-in-fact. If a claimant dies
22 after having filed a timely claim, the amount thereof shall be
23 disbursed to his surviving spouse or, if no spouse survives, to
24 his surviving dependent minor children in equal parts, provided
25 the spouse or child, as the case may be, resided with the

1 claimant at the time he filed his claim. If at the time of
2 disbursement neither the claimant nor his spouse is surviving,
3 and no dependent minor children of the claimant are surviving
4 the amount of the claim shall escheat to the State.

5 (c) One claim per household. Only one member of a household
6 may file a claim under this Act in any calendar year; where
7 both members of a household are otherwise entitled to claim a
8 grant under this Act, they must agree as to which of them will
9 file a claim for that year.

10 (d) (Blank).

11 (e) Pharmaceutical Assistance Procedures. Prior to July 1,
12 2012, the ~~The~~ Department of Healthcare and Family Services
13 shall determine eligibility for pharmaceutical assistance
14 using the applicant's current income. The Department shall
15 determine a person's current income in the manner provided by
16 the Department by rule.

17 (f) A person may not under any circumstances charge a fee
18 to a claimant under this Act for assistance in completing an
19 application form for a property tax relief grant ~~or~~
20 ~~pharmaceutical assistance~~ under this Act.

21 (Source: P.A. 96-491, eff. 8-14-09; 96-804, eff. 1-1-10;
22 96-1000, eff. 7-2-10.)

23 (320 ILCS 25/6) (from Ch. 67 1/2, par. 406)

24 Sec. 6. Administration.

25 (a) In general. Upon receipt of a timely filed claim, the

1 Department shall determine whether the claimant is a person
2 entitled to a grant under this Act and the amount of grant to
3 which he is entitled under this Act. The Department may require
4 the claimant to furnish reasonable proof of the statements of
5 domicile, household income, rent paid, property taxes accrued
6 and other matters on which entitlement is based, and may
7 withhold payment of a grant until such additional proof is
8 furnished.

9 (b) Rental determination. If the Department finds that the
10 gross rent used in the computation by a claimant of rent
11 constituting property taxes accrued exceeds the fair rental
12 value for the right to occupy that residence, the Department
13 may determine the fair rental value for that residence and
14 recompute rent constituting property taxes accrued
15 accordingly.

16 (c) Fraudulent claims. The Department shall deny claims
17 which have been fraudulently prepared or when it finds that the
18 claimant has acquired title to his residence or has paid rent
19 for his residence primarily for the purpose of receiving a
20 grant under this Act.

21 (d) (Blank). ~~Pharmaceutical Assistance. The Department~~
22 ~~shall allow all pharmacies licensed under the Pharmacy Practice~~
23 ~~Act to participate as authorized pharmacies unless they have~~
24 ~~been removed from that status for cause pursuant to the terms~~
25 ~~of this Section. The Director of the Department may enter into~~
26 ~~a written contract with any State agency, instrumentality or~~

1 ~~political subdivision, or a fiscal intermediary for the purpose~~
2 ~~of making payments to authorized pharmacies for covered~~
3 ~~prescription drugs and coordinating the program of~~
4 ~~pharmaceutical assistance established by this Act with other~~
5 ~~programs that provide payment for covered prescription drugs.~~
6 ~~Such agreement shall establish procedures for properly~~
7 ~~contracting for pharmacy services, validating reimbursement~~
8 ~~claims, validating compliance of dispensing pharmacists with~~
9 ~~the contracts for participation required under this Section,~~
10 ~~validating the reasonable costs of covered prescription drugs,~~
11 ~~and otherwise providing for the effective administration of~~
12 ~~this Act.~~

13 ~~The Department shall promulgate rules and regulations to~~
14 ~~implement and administer the program of pharmaceutical~~
15 ~~assistance required by this Act, which shall include the~~
16 ~~following:~~

17 ~~(1) Execution of contracts with pharmacies to dispense~~
18 ~~covered prescription drugs. Such contracts shall stipulate~~
19 ~~terms and conditions for authorized pharmacies~~
20 ~~participation and the rights of the State to terminate such~~
21 ~~participation for breach of such contract or for violation~~
22 ~~of this Act or related rules and regulations of the~~
23 ~~Department;~~

24 ~~(2) Establishment of maximum limits on the size of~~
25 ~~prescriptions, new or refilled, which shall be in amounts~~
26 ~~sufficient for 34 days, except as otherwise specified by~~

1 ~~rule for medical or utilization control reasons;~~

2 ~~(3) Establishment of liens upon any and all causes of~~
3 ~~action which accrue to a beneficiary as a result of~~
4 ~~injuries for which covered prescription drugs are directly~~
5 ~~or indirectly required and for which the Director made~~
6 ~~payment or became liable for under this Act;~~

7 ~~(4) Charge or collection of payments from third parties~~
8 ~~or private plans of assistance, or from other programs of~~
9 ~~public assistance for any claim that is properly chargeable~~
10 ~~under the assignment of benefits executed by beneficiaries~~
11 ~~as a requirement of eligibility for the pharmaceutical~~
12 ~~assistance identification card under this Act;~~

13 ~~(4.5) Provision for automatic enrollment of~~
14 ~~beneficiaries into a Medicare Discount Card program~~
15 ~~authorized under the federal Medicare Modernization Act of~~
16 ~~2003 (P.L. 108 391) to coordinate coverage including~~
17 ~~Medicare Transitional Assistance;~~

18 ~~(5) Inspection of appropriate records and audit of~~
19 ~~participating authorized pharmacies to ensure contract~~
20 ~~compliance, and to determine any fraudulent transactions~~
21 ~~or practices under this Act;~~

22 ~~(6) Annual determination of the reasonable costs of~~
23 ~~covered prescription drugs for which payments are made~~
24 ~~under this Act, as provided in Section 3.16 (now repealed);~~

25 ~~(7) Payment to pharmacies under this Act in accordance~~
26 ~~with the State Prompt Payment Act.~~

1 ~~The Department shall annually report to the Governor and~~
2 ~~the General Assembly by March 1st of each year on the~~
3 ~~administration of pharmaceutical assistance under this Act. By~~
4 ~~the effective date of this Act the Department shall determine~~
5 ~~the reasonable costs of covered prescription drugs in~~
6 ~~accordance with Section 3.16 of this Act (now repealed).~~

7 (Source: P.A. 96-328, eff. 8-11-09; 97-333, eff. 8-12-11.)

8 (320 ILCS 25/7) (from Ch. 67 1/2, par. 407)

9 Sec. 7. Payment and denial of claims.

10 (a) In general. The Director shall order the payment from
11 appropriations made for that purpose of grants to claimants
12 under this Act in the amounts to which the Department has
13 determined they are entitled, respectively. If a claim is
14 denied, the Director shall cause written notice of that denial
15 and the reasons for that denial to be sent to the claimant.

16 (b) Payment of claims one dollar and under. Where the
17 amount of the grant computed under Section 4 is less than one
18 dollar, the Department shall pay to the claimant one dollar.

19 (c) Right to appeal. Any person aggrieved by an action or
20 determination of the Department on Aging arising under any of
21 its powers or duties under this Act may request in writing that
22 the Department on Aging reconsider its action or determination,
23 setting out the facts upon which the request is based. The
24 Department on Aging shall consider the request and either
25 modify or affirm its prior action or determination. The

1 Department on Aging may adopt, by rule, procedures for
2 conducting its review under this Section.

3 ~~Any person aggrieved by an action or determination of the~~
4 ~~Department of Healthcare and Family Services arising under any~~
5 ~~of its powers or duties under this Act may request in writing~~
6 ~~that the Department of Healthcare and Family Services~~
7 ~~reconsider its action or determination, setting out the facts~~
8 ~~upon which the request is based. The Department of Healthcare~~
9 ~~and Family Services shall consider the request and either~~
10 ~~modify or affirm its prior action or determination. The~~
11 ~~Department of Healthcare and Family Services may adopt, by~~
12 ~~rule, procedures for conducting its review under this Section.~~

13 (d) (Blank).

14 (Source: P.A. 96-804, eff. 1-1-10.)

15 (320 ILCS 25/8) (from Ch. 67 1/2, par. 408)

16 Sec. 8. Records. Every claimant of a grant under this Act
17 and, prior to July 1, 2012, every applicant for pharmaceutical
18 assistance under this Act shall keep such records, render such
19 statements, file such forms and comply with such rules and
20 regulations as the Department on Aging may from time to time
21 prescribe. The Department on Aging may by regulations require
22 landlords to furnish to tenants statements as to gross rent or
23 rent constituting property taxes accrued.

24 (Source: P.A. 96-804, eff. 1-1-10.)

1 (320 ILCS 25/9) (from Ch. 67 1/2, par. 409)

2 Sec. 9. Fraud; error.

3 (a) Any person who files a fraudulent claim for a grant
4 under this Act, or who for compensation prepares a claim for a
5 grant and knowingly enters false information on an application
6 for any claimant under this Act, or who fraudulently files
7 multiple applications, or who fraudulently states that a
8 nondisabled person is disabled, or who, prior to July 1, 2012,
9 fraudulently procures pharmaceutical assistance benefits, or
10 who fraudulently uses such assistance to procure covered
11 prescription drugs, or who, on behalf of an authorized
12 pharmacy, files a fraudulent request for payment, is guilty of
13 a Class 4 felony for the first offense and is guilty of a Class
14 3 felony for each subsequent offense.

15 (b) (Blank). ~~The Department on Aging and the Department of~~
16 ~~Healthcare and Family Services shall immediately suspend the~~
17 ~~pharmaceutical assistance benefits of any person suspected of~~
18 ~~fraudulent procurement or fraudulent use of such assistance,~~
19 ~~and shall revoke such assistance upon a conviction. A person~~
20 ~~convicted of fraud under subsection (a) shall be permanently~~
21 ~~barred from all of the programs established under this Act.~~

22 (c) The Department on Aging may recover from a claimant any
23 amount paid to that claimant under this Act on account of an
24 erroneous or fraudulent claim, together with 6% interest per
25 year. Amounts recoverable from a claimant by the Department on
26 Aging under this Act may, but need not, be recovered by

1 offsetting the amount owed against any future grant payable to
2 the person under this Act.

3 The Department of Healthcare and Family Services may
4 recover for acts prior to July 1, 2012 from an authorized
5 pharmacy any amount paid to that pharmacy under the
6 pharmaceutical assistance program on account of an erroneous or
7 fraudulent request for payment under that program, together
8 with 6% interest per year. The Department of Healthcare and
9 Family Services may recover from a person who erroneously or
10 fraudulently obtains benefits under the pharmaceutical
11 assistance program the value of the benefits so obtained,
12 together with 6% interest per year.

13 (d) A prosecution for a violation of this Section may be
14 commenced at any time within 3 years of the commission of that
15 violation.

16 (Source: P.A. 96-804, eff. 1-1-10.)

17 (320 ILCS 25/12) (from Ch. 67 1/2, par. 412)

18 Sec. 12. Regulations - Department on Aging.

19 (a) Regulations. Notwithstanding any other provision to
20 the contrary, the Department on Aging may adopt rules regarding
21 applications, proof of eligibility, required identification
22 information, use of social security numbers, counting of
23 income, and a method of computing "gross rent" in the case of a
24 claimant living in a nursing or sheltered care home, and any
25 other rules necessary for the cost-efficient operation of the

1 program established under Section 4.

2 (b) The Department on Aging shall, to the extent of
3 appropriations made for that purpose:

4 (1) attempt to secure the cooperation of appropriate
5 federal, State and local agencies in securing the names and
6 addresses of persons to whom this Act pertains;

7 (2) prepare a mailing list of persons eligible for
8 grants under this Act;

9 (3) secure the cooperation of the Department of
10 Revenue, ~~the Department of Healthcare and Family Services,~~
11 other State agencies, and local business establishments to
12 facilitate distribution of applications under this Act to
13 those eligible to file claims; and

14 (4) through use of direct mail, newspaper
15 advertisements and radio and television advertisements,
16 and all other appropriate means of communication, conduct
17 an on-going public relations program to increase awareness
18 of eligible citizens of the benefits under this Act and the
19 procedures for applying for them.

20 (Source: P.A. 96-804, eff. 1-1-10.)

21 (320 ILCS 25/13) (from Ch. 67 1/2, par. 413)

22 Sec. 13. List of persons who have qualified. The Department
23 on Aging shall maintain a list of all persons who have
24 qualified under this Act and shall make the list available to
25 ~~the Department of Healthcare and Family Services,~~ the

1 Department of Public Health, the Secretary of State,
2 municipalities, and public transit authorities upon request.

3 All information received by a State agency, municipality,
4 or public transit authority under this Section shall be
5 confidential, except for official purposes, and any person who
6 divulges or uses that information in any manner, except in
7 accordance with a proper judicial order, shall be guilty of a
8 Class B misdemeanor.

9 (Source: P.A. 96-804, eff. 1-1-10.)

10 (320 ILCS 25/4.1 rep.)

11 Section 95. The Senior Citizens and Disabled Persons
12 Property Tax Relief and Pharmaceutical Assistance Act is
13 amended by repealing Section 4.1.

14 Section 100. The Sexual Assault Survivors Emergency
15 Treatment Act is amended by changing Section 7 as follows:

16 (410 ILCS 70/7) (from Ch. 111 1/2, par. 87-7)

17 Sec. 7. Reimbursement ~~Charges and reimbursement.~~

18 (a) When any ambulance provider furnishes transportation,
19 hospital provides hospital emergency services and forensic
20 services, hospital or health care professional or laboratory
21 provides follow-up healthcare, or pharmacy dispenses
22 prescribed medications to any sexual assault survivor, as
23 defined by the Department of Healthcare and Family Services,

1 who is neither eligible to receive such services under the
2 Illinois Public Aid Code nor covered as to such services by a
3 policy of insurance, the ambulance provider, hospital, health
4 care professional, pharmacy, or laboratory shall furnish such
5 services to that person without charge and shall be entitled to
6 be reimbursed for ~~its billed charges in~~ providing such services
7 by the Illinois Sexual Assault Emergency Treatment Program
8 under the Department of Healthcare and Family Services.
9 ~~Pharmacies shall dispense prescribed medications without~~
10 ~~charge to the survivor and shall be reimbursed~~ and at the
11 Department of Healthcare and Family Services' ~~Medicaid~~
12 allowable rates under the Illinois Public Aid Code.

13 (b) The hospital is responsible for submitting the request
14 for reimbursement for ambulance services, hospital emergency
15 services, and forensic services to the Illinois Sexual Assault
16 Emergency Treatment Program. Nothing in this Section precludes
17 hospitals from providing follow-up healthcare and receiving
18 reimbursement under this Section.

19 (c) The health care professional who provides follow-up
20 healthcare and the pharmacy that dispenses prescribed
21 medications to a sexual assault survivor are responsible for
22 submitting the request for reimbursement for follow-up
23 healthcare or pharmacy services to the Illinois Sexual Assault
24 Emergency Treatment Program.

25 (d) On and after July 1, 2012, the Department shall reduce
26 any rate of reimbursement for services or other payments or

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

5 (d) The Department of Healthcare and Family Services shall
6 establish standards, rules, and regulations to implement this
7 Section.

8 (Source: P.A. 95-331, eff. 8-21-07; 95-432, eff. 1-1-08.)

9 Section 102. The Hemophilia Care Act is amended by changing
10 Section 3 as follows:

11 (410 ILCS 420/3) (from Ch. 111 1/2, par. 2903)

12 Sec. 3. The powers and duties of the Department shall
13 include the following:

14 (1) With the advice and counsel of the Committee,
15 develop standards for determining eligibility for care and
16 treatment under this program. Among other standards
17 developed under this Section, persons suffering from
18 hemophilia must be evaluated in a center properly staffed
19 and equipped for such evaluation, but not operated by the
20 Department.

21 (2) (Blank).

22 (3) Extend financial assistance to eligible persons in
23 order that they may obtain blood and blood derivatives for
24 use in hospitals, in medical and dental facilities, or at

1 home. The Department shall extend financial assistance in
2 each fiscal year to each family containing one or more
3 eligible persons in the amount of (a) the family's eligible
4 cost of hemophilia services for that fiscal year, minus (b)
5 one fifth of its available family income for its next
6 preceding taxable year. The Director may extend financial
7 assistance in the case of unusual hardships, according to
8 specific procedures and conditions adopted for this
9 purpose in the rules and regulations promulgated by the
10 Department to implement and administer this Act.

11 (4) (Blank).

12 (5) Promulgate rules and regulations with the advice
13 and counsel of the Committee for the implementation and
14 administration of this Act.

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 Act or the Illinois Public
18 Aid Code to reduce any rate of reimbursement for services or
19 other payments in accordance with Section 5-5e of the Illinois
20 Public Aid Code.

21 (Source: P.A. 89-507, eff. 7-1-97; 90-587, eff. 7-1-98.)

22 Section 103. The Renal Disease Treatment Act is amended by
23 changing Section 3 as follows:

24 (410 ILCS 430/3) (from Ch. 111 1/2, par. 22.33)

1 Sec. 3. Duties of Departments of Healthcare and Family
2 Services and Public Health.

3 (A) The Department of Healthcare and Family Services shall:

4 (a) With the advice of the Renal Disease Advisory
5 Committee, develop standards for determining eligibility
6 for care and treatment under this program. Among other
7 standards so developed under this paragraph, candidates,
8 to be eligible for care and treatment, must be evaluated in
9 a center properly staffed and equipped for such evaluation.

10 (b) (Blank).

11 (c) (Blank).

12 (d) Extend financial assistance to persons suffering
13 from chronic renal diseases in obtaining the medical,
14 surgical, nursing, pharmaceutical, and technical services
15 necessary in caring for such diseases, including the
16 renting of home dialysis equipment. The Renal Disease
17 Advisory Committee shall recommend to the Department the
18 extent of financial assistance, including the reasonable
19 charges and fees, for:

20 (1) Treatment in a dialysis facility;

21 (2) Hospital treatment for dialysis and transplant
22 surgery;

23 (3) Treatment in a limited care facility;

24 (4) Home dialysis training; and

25 (5) Home dialysis.

26 (e) Assist in equipping dialysis centers.

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

7 (B) The Department of Public Health shall:

8 (a) Assist in the development and expansion of programs
9 for the care and treatment of persons suffering from
10 chronic renal diseases, including dialysis and other
11 medical or surgical procedures and techniques that will
12 have a lifesaving effect in the care and treatment of
13 persons suffering from these diseases.

14 (b) Assist in the development of programs for the
15 prevention of chronic renal diseases.

16 (c) Institute and carry on an educational program among
17 physicians, hospitals, public health departments, and the
18 public concerning chronic renal diseases, including the
19 dissemination of information and the conducting of
20 educational programs concerning the prevention of chronic
21 renal diseases and the methods for the care and treatment
22 of persons suffering from these diseases.

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

24 Section 104. The Code of Civil Procedure is amended by
25 changing Section 5-105 as follows:

1 (735 ILCS 5/5-105) (from Ch. 110, par. 5-105)

2 Sec. 5-105. Leave to sue or defend as an indigent person.

3 (a) As used in this Section:

4 (1) "Fees, costs, and charges" means payments imposed
5 on a party in connection with the prosecution or defense of
6 a civil action, including, but not limited to: filing fees;
7 appearance fees; fees for service of process and other
8 papers served either within or outside this State,
9 including service by publication pursuant to Section 2-206
10 of this Code and publication of necessary legal notices;
11 motion fees; jury demand fees; charges for participation
12 in, or attendance at, any mandatory process or procedure
13 including, but not limited to, conciliation, mediation,
14 arbitration, counseling, evaluation, "Children First",
15 "Focus on Children" or similar programs; fees for
16 supplementary proceedings; charges for translation
17 services; guardian ad litem fees; charges for certified
18 copies of court documents; and all other processes and
19 procedures deemed by the court to be necessary to commence,
20 prosecute, defend, or enforce relief in a civil action.

21 (2) "Indigent person" means any person who meets one or
22 more of the following criteria:

23 (i) He or she is receiving assistance under one or
24 more of the following public benefits programs:
25 Supplemental Security Income (SSI), Aid to the Aged,

1 Blind and Disabled (AABD), Temporary Assistance for
2 Needy Families (TANF), Food Stamps, General
3 Assistance, ~~State~~ Transitional Assistance, or State
4 Children and Family Assistance.

5 (ii) His or her available income is 125% or less of
6 the current poverty level as established by the United
7 States Department of Health and Human Services, unless
8 the applicant's assets that are not exempt under Part 9
9 or 10 of Article XII of this Code are of a nature and
10 value that the court determines that the applicant is
11 able to pay the fees, costs, and charges.

12 (iii) He or she is, in the discretion of the court,
13 unable to proceed in an action without payment of fees,
14 costs, and charges and whose payment of those fees,
15 costs, and charges would result in substantial
16 hardship to the person or his or her family.

17 (iv) He or she is an indigent person pursuant to
18 Section 5-105.5 of this Code.

19 (b) On the application of any person, before, or after the
20 commencement of an action, a court, on finding that the
21 applicant is an indigent person, shall grant the applicant
22 leave to sue or defend the action without payment of the fees,
23 costs, and charges of the action.

24 (c) An application for leave to sue or defend an action as
25 an indigent person shall be in writing and supported by the
26 affidavit of the applicant or, if the applicant is a minor or

1 an incompetent adult, by the affidavit of another person having
2 knowledge of the facts. The contents of the affidavit shall be
3 established by Supreme Court Rule. The court shall provide,
4 through the office of the clerk of the court, simplified forms
5 consistent with the requirements of this Section and applicable
6 Supreme Court Rules to any person seeking to sue or defend an
7 action who indicates an inability to pay the fees, costs, and
8 charges of the action. The application and supporting affidavit
9 may be incorporated into one simplified form. The clerk of the
10 court shall post in a conspicuous place in the courthouse a
11 notice no smaller than 8.5 x 11 inches, using no smaller than
12 30-point typeface printed in English and in Spanish, advising
13 the public that they may ask the court for permission to sue or
14 defend a civil action without payment of fees, costs, and
15 charges. The notice shall be substantially as follows:

16 "If you are unable to pay the fees, costs, and charges
17 of an action you may ask the court to allow you to proceed
18 without paying them. Ask the clerk of the court for forms."

19 (d) The court shall rule on applications under this Section
20 in a timely manner based on information contained in the
21 application unless the court, in its discretion, requires the
22 applicant to personally appear to explain or clarify
23 information contained in the application. If the court finds
24 that the applicant is an indigent person, the court shall enter
25 an order permitting the applicant to sue or defend without
26 payment of fees, costs, or charges. If the application is

1 denied, the court shall enter an order to that effect stating
2 the specific reasons for the denial. The clerk of the court
3 shall promptly mail or deliver a copy of the order to the
4 applicant.

5 (e) The clerk of the court shall not refuse to accept and
6 file any complaint, appearance, or other paper presented by the
7 applicant if accompanied by an application to sue or defend in
8 forma pauperis, and those papers shall be considered filed on
9 the date the application is presented. If the application is
10 denied, the order shall state a date certain by which the
11 necessary fees, costs, and charges must be paid. The court, for
12 good cause shown, may allow an applicant whose application is
13 denied to defer payment of fees, costs, and charges, make
14 installment payments, or make payment upon reasonable terms and
15 conditions stated in the order. The court may dismiss the
16 claims or defenses of any party failing to pay the fees, costs,
17 or charges within the time and in the manner ordered by the
18 court. A determination concerning an application to sue or
19 defend in forma pauperis shall not be construed as a ruling on
20 the merits.

21 (f) The court may order an indigent person to pay all or a
22 portion of the fees, costs, or charges waived pursuant to this
23 Section out of moneys recovered by the indigent person pursuant
24 to a judgment or settlement resulting from the civil action.
25 However, nothing in ~~is~~ this Section shall be construed to limit
26 the authority of a court to order another party to the action

1 to pay the fees, costs, or charges of the action.

2 (g) A court, in its discretion, may appoint counsel to
3 represent an indigent person, and that counsel shall perform
4 his or her duties without fees, charges, or reward.

5 (h) Nothing in this Section shall be construed to affect
6 the right of a party to sue or defend an action in forma
7 pauperis without the payment of fees, costs, or charges, or the
8 right of a party to court-appointed counsel, as authorized by
9 any other provision of law or by the rules of the Illinois
10 Supreme Court.

11 (i) The provisions of this Section are severable under
12 Section 1.31 of the Statute on Statutes.

13 (Source: P.A. 91-621, eff. 8-19-99; revised 11-21-11.)

14 Section 105. The Unemployment Insurance Act is amended by
15 changing Sections 1400.2, 1402, 1404, 1405, 1801.1, and 1900 as
16 follows:

17 (820 ILCS 405/1400.2)

18 Sec. 1400.2. Annual reporting and paying; household
19 workers. This Section applies to an employer who solely employs
20 one or more household workers with respect to whom the employer
21 files federal unemployment taxes as part of his or her federal
22 income tax return, or could file federal unemployment taxes as
23 part of his or her federal income tax return if the worker or
24 workers were providing services in employment for purposes of

1 the federal unemployment tax. For purposes of this Section,
2 "household worker" has the meaning ascribed to it for purposes
3 of Section 3510 of the federal Internal Revenue Code. If an
4 employer to whom this Section applies notifies the Director, in
5 writing, that he or she wishes to pay his or her contributions
6 for each quarter and submit his or her wage ~~and contribution~~
7 reports for each month or quarter, as the case may be, on an
8 annual basis, then the due date for filing the reports and
9 paying the contributions shall be April 15 of the calendar year
10 immediately following the close of the months or quarters to
11 which the reports and quarters to which the contributions
12 apply, except that the Director may, by rule, establish a
13 different due date for good cause.

14 (Source: P.A. 94-723, eff. 1-19-06.)

15 (820 ILCS 405/1402) (from Ch. 48, par. 552)

16 Sec. 1402. Penalties.

17 A. If any employer fails, within the time prescribed in
18 this Act as amended and in effect on October 5, 1980, and the
19 regulations of the Director, to file a report of wages paid to
20 each of his workers, or to file a sufficient report of such
21 wages after having been notified by the Director to do so, for
22 any period which begins prior to January 1, 1982, he shall pay
23 to the Director as a penalty a sum determined in accordance
24 with the provisions of this Act as amended and in effect on
25 October 5, 1980.

1 B. Except as otherwise provided in this Section, any
2 employer who fails to file a report of wages paid to each of
3 his workers for any period which begins on or after January 1,
4 1982, within the time prescribed by the provisions of this Act
5 and the regulations of the Director, or, if the Director
6 pursuant to such regulations extends the time for filing the
7 report, fails to file it within the extended time, shall, in
8 addition to any sum otherwise payable by him under the
9 provisions of this Act, pay to the Director as a penalty a sum
10 equal to the lesser of (1) \$5 for each \$10,000 or fraction
11 thereof of the total wages for insured work paid by him during
12 the period or (2) \$2,500, for each month or part thereof of
13 such failure to file the report. With respect to an employer
14 who has elected to file reports of wages on an annual basis
15 pursuant to Section 1400.2, in assessing penalties for the
16 failure to submit all reports by the due date established
17 pursuant to that Section, the 30-day period immediately
18 following the due date shall be considered as one month.

19 If the Director deems an employer's report of wages paid to
20 each of his workers for any period which begins on or after
21 January 1, 1982, insufficient, he shall notify the employer to
22 file a sufficient report. If the employer fails to file such
23 sufficient report within 30 days after the mailing of the
24 notice to him, he shall, in addition to any sum otherwise
25 payable by him under the provisions of this Act, pay to the
26 Director as a penalty a sum determined in accordance with the

1 provisions of the first paragraph of this subsection, for each
2 month or part thereof of such failure to file such sufficient
3 report after the date of the notice.

4 For wages paid in calendar years prior to 1988, the penalty
5 or penalties which accrue under the two foregoing paragraphs
6 with respect to a report for any period shall not be less than
7 \$100, and shall not exceed the lesser of (1) \$10 for each
8 \$10,000 or fraction thereof of the total wages for insured work
9 paid during the period or (2) \$5,000. For wages paid in
10 calendar years after 1987, the penalty or penalties which
11 accrue under the 2 foregoing paragraphs with respect to a
12 report for any period shall not be less than \$50, and shall not
13 exceed the lesser of (1) \$10 for each \$10,000 or fraction of
14 the total wages for insured work paid during the period or (2)
15 \$5,000. With respect to an employer who has elected to file
16 reports of wages on an annual basis pursuant to Section 1400.2,
17 for purposes of calculating the minimum penalty prescribed by
18 this Section for failure to file the reports on a timely basis,
19 a calendar year shall constitute a single period. For reports
20 of wages paid after 1986, the Director shall not, however,
21 impose a penalty pursuant to either of the two foregoing
22 paragraphs on any employer who can prove within 30 working days
23 after the mailing of a notice of his failure to file such a
24 report, that (1) the failure to file the report is his first
25 such failure during the previous 20 consecutive calendar
26 quarters, and (2) the amount of the total contributions due for

1 the calendar quarter of such report (or, in the case of an
2 employer who is required to file the reports on a monthly
3 basis, the amount of the total contributions due for the
4 calendar quarter that includes the month of such report) is
5 less than \$500.

6 For any month which begins on or after January 1, 2013, a
7 report of the wages paid to each of an employer's workers shall
8 be due on or before the last day of the month next following
9 the calendar month in which the wages were paid if the employer
10 is required to report such wages electronically pursuant to the
11 regulations of the Director; otherwise a report of the wages
12 paid to each of the employer's workers shall be due on or
13 before the last day of the month next following the calendar
14 quarter in which the wages were paid.

15 Any employer who wilfully fails to pay any contribution or
16 part thereof, based upon wages paid prior to 1987, when
17 required by the provisions of this Act and the regulations of
18 the Director, with intent to defraud the Director, shall in
19 addition to such contribution or part thereof pay to the
20 Director a penalty equal to 50 percent of the amount of such
21 contribution or part thereof, as the case may be, provided that
22 the penalty shall not be less than \$200.

23 Any employer who willfully fails to pay any contribution or
24 part thereof, based upon wages paid in 1987 and in each
25 calendar year thereafter, when required by the provisions of
26 this Act and the regulations of the Director, with intent to

1 defraud the Director, shall in addition to such contribution or
2 part thereof pay to the Director a penalty equal to 60% of the
3 amount of such contribution or part thereof, as the case may
4 be, provided that the penalty shall not be less than \$400.

5 However, all or part of any penalty may be waived by the
6 Director for good cause shown.

7 (Source: P.A. 94-723, eff. 1-19-06.)

8 (820 ILCS 405/1404) (from Ch. 48, par. 554)

9 Sec. 1404. Payments in lieu of contributions by nonprofit
10 organizations. A. For the year 1972 and for each calendar year
11 thereafter, contributions shall accrue and become payable,
12 pursuant to Section 1400, by each nonprofit organization
13 (defined in Section 211.2) upon the wages paid by it with
14 respect to employment after 1971, unless the nonprofit
15 organization elects, in accordance with the provisions of this
16 Section, to pay, in lieu of contributions, an amount equal to
17 the amount of regular benefits and one-half the amount of
18 extended benefits (defined in Section 409) paid to individuals,
19 for any weeks which begin on or after the effective date of the
20 election, on the basis of wages for insured work paid to them
21 by such nonprofit organization during the effective period of
22 such election. Notwithstanding the preceding provisions of
23 this subsection and the provisions of subsection D, with
24 respect to benefit years beginning prior to July 1, 1989, any
25 adjustment after September 30, 1989 to the base period wages

1 paid to the individual by any employer shall not affect the
2 ratio for determining the payments in lieu of contributions of
3 a nonprofit organization which has elected to make payments in
4 lieu of contributions. Provided, however, that with respect to
5 benefit years beginning on or after July 1, 1989, the nonprofit
6 organization shall be required to make payments equal to 100%
7 of regular benefits, including dependents' allowances, and 50%
8 of extended benefits, including dependents' allowances, paid
9 to an individual with respect to benefit years beginning during
10 the effective period of the election, but only if the nonprofit
11 organization: (a) is the last employer as provided in Section
12 1502.1 and (b) paid to the individual receiving benefits, wages
13 for insured work during his base period. If the nonprofit
14 organization described in this paragraph meets the
15 requirements of (a) but not (b), with respect to benefit years
16 beginning on or after July 1, 1989, it shall be required to
17 make payments in an amount equal to 50% of regular benefits,
18 including dependents' allowances, and 25% of extended
19 benefits, including dependents' allowances, paid to an
20 individual with respect to benefit years beginning during the
21 effective period of the election.

22 1. Any employing unit which becomes a nonprofit
23 organization on January 1, 1972, may elect to make payments in
24 lieu of contributions for not less than one calendar year
25 beginning with January 1, 1972, provided that it files its
26 written election with the Director not later than January 31,

1 1972.

2 2. Any employing unit which becomes a nonprofit
3 organization after January 1, 1972, may elect to make payments
4 in lieu of contributions for a period of not less than one
5 calendar year beginning as of the first day with respect to
6 which it would, in the absence of its election, incur liability
7 for the payment of contributions, provided that it files its
8 written election with the Director not later than 30 days
9 immediately following the end of the calendar quarter in which
10 it becomes a nonprofit organization.

11 3. A nonprofit organization which has incurred liability
12 for the payment of contributions for at least 2 calendar years
13 and is not delinquent in such payment and in the payment of any
14 interest or penalties which may have accrued, may elect to make
15 payments in lieu of contributions beginning January 1 of any
16 calendar year, provided that it files its written election with
17 the Director prior to such January 1, and provided, further,
18 that such election shall be for a period of not less than 2
19 calendar years.

20 4. An election to make payments in lieu of contributions
21 shall not terminate any liability incurred by an employer for
22 the payment of contributions, interest or penalties with
23 respect to any calendar quarter (or month, as the case may be)
24 which ends prior to the effective period of the election.

25 5. A nonprofit organization which has elected, pursuant to
26 paragraph 1, 2, or 3, to make payments in lieu of contributions

1 may terminate the effective period of the election as of
2 January 1 of any calendar year subsequent to the required
3 minimum period of the election only if, prior to such January
4 1, it files with the Director a written notice to that effect.
5 Upon such termination, the organization shall become liable for
6 the payment of contributions upon wages for insured work paid
7 by it on and after such January 1 and, notwithstanding such
8 termination, it shall continue to be liable for payments in
9 lieu of contributions with respect to benefits paid to
10 individuals on and after such January 1, with respect to
11 benefit years beginning prior to July 1, 1989, on the basis of
12 wages for insured work paid to them by the nonprofit
13 organization prior to such January 1, and, with respect to
14 benefit years beginning after June 30, 1989, if such employer
15 was the last employer as provided in Section 1502.1 during a
16 benefit year beginning prior to such January 1.

17 6. Written elections to make payments in lieu of
18 contributions and written notices of termination of election
19 shall be filed in such form and shall contain such information
20 as the Director may prescribe. Upon the filing of such election
21 or notice, the Director shall either order it approved, or, if
22 it appears to the Director that the nonprofit organization has
23 not filed such election or notice within the time prescribed,
24 he shall order it disapproved. The Director shall serve notice
25 of his order upon the nonprofit organization. The Director's
26 order shall be final and conclusive upon the nonprofit

1 organization unless, within 15 days after the date of mailing
2 of notice thereof, the nonprofit organization files with the
3 Director an application for its review, setting forth its
4 reasons in support thereof. Upon receipt of an application for
5 review within the time prescribed, the Director shall order it
6 allowed, or shall order that it be denied, and shall serve
7 notice upon the nonprofit organization of his order. All of the
8 provisions of Section 1509, applicable to orders denying
9 applications for review of determinations of employers' rates
10 of contribution and not inconsistent with the provisions of
11 this subsection, shall be applicable to an order denying an
12 application for review filed pursuant to this subsection.

13 B. As soon as practicable following the close of each
14 calendar quarter, the Director shall mail to each nonprofit
15 organization which has elected to make payments in lieu of
16 contributions a Statement of the amount due from it for the
17 regular and one-half the extended benefits paid (or the amounts
18 otherwise provided for in subsection A) during the calendar
19 quarter, together with the names of its workers or former
20 workers and the amounts of benefits paid to each of them during
21 the calendar quarter, with respect to benefit years beginning
22 prior to July 1, 1989, on the basis of wages for insured work
23 paid to them by the nonprofit organization; or, with respect to
24 benefit years beginning after June 30, 1989, if such nonprofit
25 organization was the last employer as provided in Section
26 1502.1 with respect to a benefit year beginning during the

1 effective period of the election. The amount due shall be
2 payable, and the nonprofit organization shall make payment of
3 such amount not later than 30 days after the date of mailing of
4 the Statement. The Statement shall be final and conclusive upon
5 the nonprofit organization unless, within 20 days after the
6 date of mailing of the Statement, the nonprofit organization
7 files with the Director an application for revision thereof.
8 Such application shall specify wherein the nonprofit
9 organization believes the Statement to be incorrect, and shall
10 set forth its reasons for such belief. All of the provisions of
11 Section 1508, applicable to applications for revision of
12 Statements of Benefit Wages and Statements of Benefit Charges
13 and not inconsistent with the provisions of this subsection,
14 shall be applicable to an application for revision of a
15 Statement filed pursuant to this subsection.

16 1. Payments in lieu of contributions made by any nonprofit
17 organization shall not be deducted or deductible, in whole or
18 in part, from the remuneration of individuals in the employ of
19 the organization, nor shall any nonprofit organization require
20 or accept any waiver of any right under this Act by an
21 individual in its employ. The making of any such deduction or
22 the requirement or acceptance of any such waiver is a Class A
23 misdemeanor. Any agreement by an individual in the employ of
24 any person or concern to pay all or any portion of a payment in
25 lieu of contributions, required under this Act from a nonprofit
26 organization, is void.

1 2. A nonprofit organization which fails to make any payment
2 in lieu of contributions when due under the provisions of this
3 subsection shall pay interest thereon at the rates specified in
4 Section 1401. A nonprofit organization which has elected to
5 make payments in lieu of contributions shall be subject to the
6 penalty provisions of Section 1402. In the making of any
7 payment in lieu of contributions or in the payment of any
8 interest or penalties, a fractional part of a cent shall be
9 disregarded unless it amounts to one-half cent or more, in
10 which case it shall be increased to one cent.

11 3. All of the remedies available to the Director under the
12 provisions of this Act or of any other law to enforce the
13 payment of contributions, interest, or penalties under this
14 Act, including the making of determinations and assessments
15 pursuant to Section 2200, are applicable to the enforcement of
16 payments in lieu of contributions and of interest and
17 penalties, due under the provisions of this Section. For the
18 purposes of this paragraph, the term "contribution" or
19 "contributions" which appears in any such provision means
20 "payment in lieu of contributions" or "payments in lieu of
21 contributions." The term "contribution" which appears in
22 Section 2800 also means "payment in lieu of contributions."

23 4. All of the provisions of Sections 2201 and 2201.1,
24 applicable to adjustment or refund of contributions, interest
25 and penalties erroneously paid and not inconsistent with the
26 provisions of this Section, shall be applicable to payments in

1 lieu of contributions erroneously made or interest or penalties
2 erroneously paid by a nonprofit organization.

3 5. Payment in lieu of contributions shall be due with
4 respect to any sum erroneously paid as benefits to an
5 individual unless such sum has been recouped pursuant to
6 Section 900 or has otherwise been recovered. If such payment in
7 lieu of contributions has been made, the amount thereof shall
8 be adjusted or refunded in accordance with the provisions of
9 paragraph 4 and Section 2201 if recoupment or other recovery
10 has been made.

11 6. A nonprofit organization which has elected to make
12 payments in lieu of contributions and thereafter ceases to be
13 an employer shall continue to be liable for payments in lieu of
14 contributions with respect to benefits paid to individuals on
15 and after the date it has ceased to be an employer, with
16 respect to benefit years beginning prior to July 1, 1989, on
17 the basis of wages for insured work paid to them by it prior to
18 the date it ceased to be an employer, and, with respect to
19 benefit years beginning after June 30, 1989, if such employer
20 was the last employer as provided in Section 1502.1 prior to
21 the date that it ceased to be an employer.

22 7. With respect to benefit years beginning prior to July 1,
23 1989, wages paid to an individual during his base period, by a
24 nonprofit organization which elects to make payments in lieu of
25 contributions, for less than full time work, performed during
26 the same weeks in the base period during which the individual

1 had other insured work, shall not be subject to payments in
2 lieu of contributions (upon such employer's request pursuant to
3 the regulation of the Director) so long as the employer
4 continued after the end of the base period, and continues
5 during the applicable benefit year, to furnish such less than
6 full time work to the individual on the same basis and in
7 substantially the same amount as during the base period. If the
8 individual is paid benefits with respect to a week (in the
9 applicable benefit year) after the employer has ceased to
10 furnish the work hereinabove described, the nonprofit
11 organization shall be liable for payments in lieu of
12 contributions with respect to the benefits paid to the
13 individual after the date on which the nonprofit organization
14 ceases to furnish the work.

15 C. With respect to benefit years beginning prior to July 1,
16 1989, whenever benefits have been paid to an individual on the
17 basis of wages for insured work paid to him by a nonprofit
18 organization, and the organization incurred liability for the
19 payment of contributions on some of the wages because only a
20 part of the individual's base period was within the effective
21 period of the organization's written election to make payments
22 in lieu of contributions, the organization shall pay an amount
23 in lieu of contributions which bears the same ratio to the
24 total benefits paid to the individual as the total wages for
25 insured work paid to him during the base period by the
26 organization upon which it did not incur liability for the

1 payment of contributions (for the aforesaid reason) bear to the
2 total wages for insured work paid to the individual during the
3 base period by the organization.

4 D. With respect to benefit years beginning prior to July 1,
5 1989, whenever benefits have been paid to an individual on the
6 basis of wages for insured work paid to him by a nonprofit
7 organization which has elected to make payments in lieu of
8 contributions, and by one or more other employers, the
9 nonprofit organization shall pay an amount in lieu of
10 contributions which bears the same ratio to the total benefits
11 paid to the individual as the wages for insured work paid to
12 the individual during his base period by the nonprofit
13 organization bear to the total wages for insured work paid to
14 the individual during the base period by all of the employers.
15 If the nonprofit organization incurred liability for the
16 payment of contributions on some of the wages for insured work
17 paid to the individual, it shall be treated, with respect to
18 such wages, as one of the other employers for the purposes of
19 this paragraph.

20 E. Two or more nonprofit organizations which have elected
21 to make payments in lieu of contributions may file a joint
22 application with the Director for the establishment of a group
23 account, effective January 1 of any calendar year, for the
24 purpose of sharing the cost of benefits paid on the basis of
25 the wages for insured work paid by such nonprofit
26 organizations, provided that such joint application is filed

1 with the Director prior to such January 1. The application
2 shall identify and authorize a group representative to act as
3 the group's agent for the purposes of this paragraph, and shall
4 be filed in such form and shall contain such information as the
5 Director may prescribe. Upon his approval of a joint
6 application, the Director shall, by order, establish a group
7 account for the applicants and shall serve notice upon the
8 group's representative of such order. Such account shall remain
9 in effect for not less than 2 calendar years and thereafter
10 until terminated by the Director for good cause or, as of the
11 close of any calendar quarter, upon application by the group.
12 Upon establishment of the account, the group shall be liable to
13 the Director for payments in lieu of contributions in an amount
14 equal to the total amount for which, in the absence of the
15 group account, liability would have been incurred by all of its
16 members; provided, with respect to benefit years beginning
17 prior to July 1, 1989, that the liability of any member to the
18 Director with respect to any payment in lieu of contributions,
19 interest or penalties not paid by the group when due with
20 respect to any calendar quarter shall be in an amount which
21 bears the same ratio to the total benefits paid during such
22 quarter on the basis of the wages for insured work paid by all
23 members of the group as the total wages for insured work paid
24 by such member during such quarter bear to the total wages for
25 insured work paid during the quarter by all members of the
26 group, and, with respect to benefit years beginning on or after

1 July 1, 1989, that the liability of any member to the Director
2 with respect to any payment in lieu of contributions, interest
3 or penalties not paid by the group when due with respect to any
4 calendar quarter shall be in an amount which bears the same
5 ratio to the total benefits paid during such quarter to
6 individuals with respect to whom any member of the group was
7 the last employer as provided in Section 1502.1 as the total
8 wages for insured work paid by such member during such quarter
9 bear to the total wages for insured work paid during the
10 quarter by all members of the group. With respect to calendar
11 months and quarters beginning on or after January 1, 2013, the
12 liability of any member to the Director with respect to any
13 penalties that are assessed for failure to file a timely and
14 sufficient report of wages and which are not paid by the group
15 when due with respect to the calendar month or quarter, as the
16 case may be, shall be in an amount which bears the same ratio
17 to the total penalties due with respect to such month or
18 quarter as the total wages for insured work paid by such member
19 during such month or quarter bear to the total wages for
20 insured work paid during the month or quarter by all members of
21 the group. All of the provisions of this Section applicable to
22 nonprofit organizations which have elected to make payments in
23 lieu of contributions, and not inconsistent with the provisions
24 of this paragraph, shall apply to a group account and, upon its
25 termination, to each former member thereof. The Director shall
26 by regulation prescribe the conditions for establishment,

1 maintenance and termination of group accounts, and for addition
2 of new members to and withdrawal of active members from such
3 accounts.

4 F. Whenever service of notice is required by this Section,
5 such notice may be given and be complete by depositing it with
6 the United States Mail, addressed to the nonprofit organization
7 (or, in the case of a group account, to its representative) at
8 its last known address. If such organization is represented by
9 counsel in proceedings before the Director, service of notice
10 may be made upon the nonprofit organization by mailing the
11 notice to such counsel.

12 (Source: P.A. 86-3.)

13 (820 ILCS 405/1405) (from Ch. 48, par. 555)

14 Sec. 1405. Financing Benefits for Employees of Local
15 Governments.

16 A. 1. For the year 1978 and for each calendar year
17 thereafter, contributions shall accrue and become payable,
18 pursuant to Section 1400, by each governmental entity (other
19 than the State of Illinois and its wholly owned
20 instrumentalities) referred to in clause (B) of Section 211.1,
21 upon the wages paid by such entity with respect to employment
22 after 1977, unless the entity elects to make payments in lieu
23 of contributions pursuant to the provisions of subsection B.
24 Notwithstanding the provisions of Sections 1500 to 1510,
25 inclusive, a governmental entity which has not made such

1 election shall, for liability for contributions incurred prior
2 to January 1, 1984, pay contributions equal to 1 percent with
3 respect to wages for insured work paid during each such
4 calendar year or portion of such year as may be applicable. As
5 used in this subsection, the word "wages", defined in Section
6 234, is subject to all of the provisions of Section 235.

7 2. An Indian tribe for which service is exempted from the
8 federal unemployment tax under Section 3306(c)(7) of the
9 Federal Unemployment Tax Act may elect to make payments in lieu
10 of contributions in the same manner and subject to the same
11 conditions as provided in this Section with regard to
12 governmental entities, except as otherwise provided in
13 paragraphs 7, 8, and 9 of subsection B.

14 B. Any governmental entity subject to subsection A may
15 elect to make payments in lieu of contributions, in amounts
16 equal to the amounts of regular and extended benefits paid to
17 individuals, for any weeks which begin on or after the
18 effective date of the election, on the basis of wages for
19 insured work paid to them by the entity during the effective
20 period of such election. Notwithstanding the preceding
21 provisions of this subsection and the provisions of subsection
22 D of Section 1404, with respect to benefit years beginning
23 prior to July 1, 1989, any adjustment after September 30, 1989
24 to the base period wages paid to the individual by any employer
25 shall not affect the ratio for determining payments in lieu of
26 contributions of a governmental entity which has elected to

1 make payments in lieu of contributions. Provided, however, that
2 with respect to benefit years beginning on or after July 1,
3 1989, the governmental entity shall be required to make
4 payments equal to 100% of regular benefits, including
5 dependents' allowances, and 100% of extended benefits,
6 including dependents' allowances, paid to an individual with
7 respect to benefit years beginning during the effective period
8 of the election, but only if the governmental entity: (a) is
9 the last employer as provided in Section 1502.1 and (b) paid to
10 the individual receiving benefits, wages for insured work
11 during his base period. If the governmental entity described in
12 this paragraph meets the requirements of (a) but not (b), with
13 respect to benefit years beginning on or after July 1, 1989, it
14 shall be required to make payments in an amount equal to 50% of
15 regular benefits, including dependents' allowances, and 50% of
16 extended benefits, including dependents' allowances, paid to
17 an individual with respect to benefit years beginning during
18 the effective period of the election.

19 1. Any such governmental entity which becomes an employer
20 on January 1, 1978 pursuant to Section 205 may elect to make
21 payments in lieu of contributions for not less than one
22 calendar year beginning with January 1, 1978, provided that it
23 files its written election with the Director not later than
24 January 31, 1978.

25 2. A governmental entity newly created after January 1,
26 1978, may elect to make payments in lieu of contributions for a

1 period of not less than one calendar year beginning as of the
2 first day with respect to which it would, in the absence of its
3 election, incur liability for the payment of contributions,
4 provided that it files its written election with the Director
5 not later than 30 days immediately following the end of the
6 calendar quarter in which it has been created.

7 3. A governmental entity which has incurred liability for
8 the payment of contributions for at least 2 calendar years, and
9 is not delinquent in such payment and in the payment of any
10 interest or penalties which may have accrued, may elect to make
11 payments in lieu of contributions beginning January 1 of any
12 calendar year, provided that it files its written election with
13 the Director prior to such January 1, and provided, further,
14 that such election shall be for a period of not less than 2
15 calendar years.

16 4. An election to make payments in lieu of contributions
17 shall not terminate any liability incurred by a governmental
18 entity for the payment of contributions, interest or penalties
19 with respect to any calendar quarter (or month, as the case may
20 be) which ends prior to the effective period of the election.

21 5. The termination by a governmental entity of the
22 effective period of its election to make payments in lieu of
23 contributions, and the filing of and subsequent action upon
24 written notices of termination of election, shall be governed
25 by the provisions of paragraphs 5 and 6 of Section 1404A,
26 pertaining to nonprofit organizations.

1 6. With respect to benefit years beginning prior to July 1,
2 1989, wages paid to an individual during his base period by a
3 governmental entity which elects to make payments in lieu of
4 contributions for less than full time work, performed during
5 the same weeks in the base period during which the individual
6 had other insured work, shall not be subject to payments in
7 lieu of contribution (upon such employer's request pursuant to
8 the regulation of the Director) so long as the employer
9 continued after the end of the base period, and continues
10 during the applicable benefit year, to furnish such less than
11 full time work to the individual on the same basis and in
12 substantially the same amount as during the base period. If the
13 individual is paid benefits with respect to a week (in the
14 applicable benefit year) after the employer has ceased to
15 furnish the work hereinabove described, the governmental
16 entity shall be liable for payments in lieu of contributions
17 with respect to the benefits paid to the individual after the
18 date on which the governmental entity ceases to furnish the
19 work.

20 7. An Indian tribe may elect to make payments in lieu of
21 contributions for calendar year 2003, provided that it files
22 its written election with the Director not later than January
23 31, 2003, and provided further that it is not delinquent in the
24 payment of any contributions, interest, or penalties.

25 8. Failure of an Indian tribe to make a payment in lieu of
26 contributions, or a payment of interest or penalties due under

1 this Act, within 90 days after the Department serves notice of
2 the finality of a determination and assessment shall cause the
3 Indian tribe to lose the option of making payments in lieu of
4 contributions, effective as of the calendar year immediately
5 following the date on which the Department serves the notice.
6 Notice of the loss of the option to make payments in lieu of
7 contributions may be protested in the same manner as a
8 determination and assessment under Section 2200 of this Act.

9 9. An Indian tribe that, pursuant to paragraph 8, loses the
10 option of making payments in lieu of contributions may again
11 elect to make payments in lieu of contributions for a calendar
12 year if: (a) the Indian tribe has incurred liability for the
13 payment of contributions for at least one calendar year since
14 losing the option pursuant to paragraph 8, (b) the Indian tribe
15 is not delinquent in the payment of any liabilities under the
16 Act, including interest or penalties, and (c) the Indian tribe
17 files its written election with the Director not later than
18 January 31 of the year with respect to which it is making the
19 election.

20 C. As soon as practicable following the close of each
21 calendar quarter, the Director shall mail to each governmental
22 entity which has elected to make payments in lieu of
23 contributions a Statement of the amount due from it for all the
24 regular and extended benefits paid during the calendar quarter,
25 together with the names of its workers or former workers and
26 the amounts of benefits paid to each of them during the

1 calendar quarter with respect to benefit years beginning prior
2 to July 1, 1989, on the basis of wages for insured work paid to
3 them by the governmental entity; or, with respect to benefit
4 years beginning after June 30, 1989, if such governmental
5 entity was the last employer as provided in Section 1502.1 with
6 respect to a benefit year beginning during the effective period
7 of the election. All of the provisions of subsection B of
8 Section 1404 pertaining to nonprofit organizations, not
9 inconsistent with the preceding sentence, shall be applicable
10 to payments in lieu of contributions by a governmental entity.

11 D. The provisions of subsections C through F, inclusive, of
12 Section 1404, pertaining to nonprofit organizations, shall be
13 applicable to each governmental entity which has elected to
14 make payments in lieu of contributions.

15 E. 1. If an Indian tribe fails to pay any liability under
16 this Act (including assessments of interest or penalty) within
17 90 days after the Department issues a notice of the finality of
18 a determination and assessment, the Director shall immediately
19 notify the United States Internal Revenue Service and the
20 United States Department of Labor.

21 2. Notices of payment and reporting delinquencies to Indian
22 tribes shall include information that failure to make full
23 payment within the prescribed time frame:

24 a. will cause the Indian tribe to lose the exemption
25 provided by Section 3306(c)(7) of the Federal Unemployment
26 Tax Act with respect to the federal unemployment tax;

1 b. will cause the Indian tribe to lose the option to
2 make payments in lieu of contributions.

3 (Source: P.A. 92-555, eff. 6-24-02.)

4 (820 ILCS 405/1801.1)

5 Sec. 1801.1. Directory of New Hires.

6 A. The Director shall establish and operate an automated
7 directory of newly hired employees which shall be known as the
8 "Illinois Directory of New Hires" which shall contain the
9 information required to be reported by employers to the
10 Department under subsection B. In the administration of the
11 Directory, the Director shall comply with any requirements
12 concerning the Employer New Hire Reporting Program established
13 by the federal Personal Responsibility and Work Opportunity
14 Reconciliation Act of 1996. The Director is authorized to use
15 the information contained in the Directory of New Hires to
16 administer any of the provisions of this Act.

17 B. Each employer in Illinois, except a department, agency,
18 or instrumentality of the United States, shall file with the
19 Department a report in accordance with rules adopted by the
20 Department (but in any event not later than 20 days after the
21 date the employer hires the employee or, in the case of an
22 employer transmitting reports magnetically or electronically,
23 by 2 monthly transmissions, if necessary, not less than 12 days
24 nor more than 16 days apart) providing the following
25 information concerning each newly hired employee: the

1 employee's name, address, and social security number, the date
2 services for remuneration were first performed by the employee,
3 the employee's projected monthly wages, and the employer's
4 name, address, Federal Employer Identification Number assigned
5 under Section 6109 of the Internal Revenue Code of 1986, and
6 such other information as may be required by federal law or
7 regulation, provided that each employer may voluntarily file
8 the address to which the employer wants income withholding
9 orders to be mailed, if it is different from the address given
10 on the Federal Employer Identification Number. An employer in
11 Illinois which transmits its reports electronically or
12 magnetically and which also has employees in another state may
13 report all newly hired employees to a single designated state
14 in which the employer has employees if it has so notified the
15 Secretary of the United States Department of Health and Human
16 Services in writing. An employer may, at its option, submit
17 information regarding any rehired employee in the same manner
18 as information is submitted regarding a newly hired employee.
19 Each report required under this subsection shall, to the extent
20 practicable, be made on an Internal Revenue Service Form W-4
21 or, at the option of the employer, an equivalent form, and may
22 be transmitted by first class mail, by telefax, magnetically,
23 or electronically.

24 C. An employer which knowingly fails to comply with the
25 reporting requirements established by this Section shall be
26 subject to a civil penalty of \$15 for each individual whom it

1 fails to report. An employer shall be considered to have
2 knowingly failed to comply with the reporting requirements
3 established by this Section with respect to an individual if
4 the employer has been notified by the Department that it has
5 failed to report an individual, and it fails, without
6 reasonable cause, to supply the required information to the
7 Department within 21 days after the date of mailing of the
8 notice. Any individual who knowingly conspires with the newly
9 hired employee to cause the employer to fail to report the
10 information required by this Section or who knowingly conspires
11 with the newly hired employee to cause the employer to file a
12 false or incomplete report shall be guilty of a Class B
13 misdemeanor with a fine not to exceed \$500 with respect to each
14 employee with whom the individual so conspires.

15 D. As used in this Section, "newly hired employee" means an
16 individual who is an employee within the meaning of Chapter 24
17 of the Internal Revenue Code of 1986, and whose reporting to
18 work which results in earnings from the employer is the first
19 instance within the preceding 180 days that the individual has
20 reported for work for which earnings were received from that
21 employer; however, "newly hired employee" does not include an
22 employee of a federal or State agency performing intelligence
23 or counterintelligence functions, if the head of that agency
24 has determined that the filing of the report required by this
25 Section with respect to the employee could endanger the safety
26 of the employee or compromise an ongoing investigation or

1 intelligence mission.

2 Notwithstanding Section 205, and for the purposes of this
3 Section only, the term "employer" has the meaning given by
4 Section 3401(d) of the Internal Revenue Code of 1986 and
5 includes any governmental entity and labor organization as
6 defined by Section 2(5) of the National Labor Relations Act,
7 and includes any entity (also known as a hiring hall) which is
8 used by the organization and an employer to carry out the
9 requirements described in Section 8(f)(3) of that Act of an
10 agreement between the organization and the employer.

11 (Source: P.A. 97-621, eff. 11-18-11.)

12 (820 ILCS 405/1900) (from Ch. 48, par. 640)

13 Sec. 1900. Disclosure of information.

14 A. Except as provided in this Section, information obtained
15 from any individual or employing unit during the administration
16 of this Act shall:

17 1. be confidential,

18 2. not be published or open to public inspection,

19 3. not be used in any court in any pending action or
20 proceeding,

21 4. not be admissible in evidence in any action or
22 proceeding other than one arising out of this Act.

23 B. No finding, determination, decision, ruling or order
24 (including any finding of fact, statement or conclusion made
25 therein) issued pursuant to this Act shall be admissible or

1 used in evidence in any action other than one arising out of
2 this Act, nor shall it be binding or conclusive except as
3 provided in this Act, nor shall it constitute res judicata,
4 regardless of whether the actions were between the same or
5 related parties or involved the same facts.

6 C. Any officer or employee of this State, any officer or
7 employee of any entity authorized to obtain information
8 pursuant to this Section, and any agent of this State or of
9 such entity who, except with authority of the Director under
10 this Section, shall disclose information shall be guilty of a
11 Class B misdemeanor and shall be disqualified from holding any
12 appointment or employment by the State.

13 D. An individual or his duly authorized agent may be
14 supplied with information from records only to the extent
15 necessary for the proper presentation of his claim for benefits
16 or with his existing or prospective rights to benefits.
17 Discretion to disclose this information belongs solely to the
18 Director and is not subject to a release or waiver by the
19 individual. Notwithstanding any other provision to the
20 contrary, an individual or his or her duly authorized agent may
21 be supplied with a statement of the amount of benefits paid to
22 the individual during the 18 months preceding the date of his
23 or her request.

24 E. An employing unit may be furnished with information,
25 only if deemed by the Director as necessary to enable it to
26 fully discharge its obligations or safeguard its rights under

1 the Act. Discretion to disclose this information belongs solely
2 to the Director and is not subject to a release or waiver by
3 the employing unit.

4 F. The Director may furnish any information that he may
5 deem proper to any public officer or public agency of this or
6 any other State or of the federal government dealing with:

- 7 1. the administration of relief,
- 8 2. public assistance,
- 9 3. unemployment compensation,
- 10 4. a system of public employment offices,
- 11 5. wages and hours of employment, or
- 12 6. a public works program.

13 The Director may make available to the Illinois Workers'
14 Compensation Commission information regarding employers for
15 the purpose of verifying the insurance coverage required under
16 the Workers' Compensation Act and Workers' Occupational
17 Diseases Act.

18 G. The Director may disclose information submitted by the
19 State or any of its political subdivisions, municipal
20 corporations, instrumentalities, or school or community
21 college districts, except for information which specifically
22 identifies an individual claimant.

23 H. The Director shall disclose only that information
24 required to be disclosed under Section 303 of the Social
25 Security Act, as amended, including:

- 26 1. any information required to be given the United

1 States Department of Labor under Section 303(a)(6); and

2 2. the making available upon request to any agency of
3 the United States charged with the administration of public
4 works or assistance through public employment, the name,
5 address, ordinary occupation and employment status of each
6 recipient of unemployment compensation, and a statement of
7 such recipient's right to further compensation under such
8 law as required by Section 303(a)(7); and

9 3. records to make available to the Railroad Retirement
10 Board as required by Section 303(c)(1); and

11 4. information that will assure reasonable cooperation
12 with every agency of the United States charged with the
13 administration of any unemployment compensation law as
14 required by Section 303(c)(2); and

15 5. information upon request and on a reimbursable basis
16 to the United States Department of Agriculture and to any
17 State food stamp agency concerning any information
18 required to be furnished by Section 303(d); and

19 6. any wage information upon request and on a
20 reimbursable basis to any State or local child support
21 enforcement agency required by Section 303(e); and

22 7. any information required under the income
23 eligibility and verification system as required by Section
24 303(f); and

25 8. information that might be useful in locating an
26 absent parent or that parent's employer, establishing

1 paternity or establishing, modifying, or enforcing child
2 support orders for the purpose of a child support
3 enforcement program under Title IV of the Social Security
4 Act upon the request of and on a reimbursable basis to the
5 public agency administering the Federal Parent Locator
6 Service as required by Section 303(h); and

7 9. information, upon request, to representatives of
8 any federal, State or local governmental public housing
9 agency with respect to individuals who have signed the
10 appropriate consent form approved by the Secretary of
11 Housing and Urban Development and who are applying for or
12 participating in any housing assistance program
13 administered by the United States Department of Housing and
14 Urban Development as required by Section 303(i).

15 I. The Director, upon the request of a public agency of
16 Illinois, of the federal government or of any other state
17 charged with the investigation or enforcement of Section 10-5
18 of the Criminal Code of 1961 (or a similar federal law or
19 similar law of another State), may furnish the public agency
20 information regarding the individual specified in the request
21 as to:

22 1. the current or most recent home address of the
23 individual, and

24 2. the names and addresses of the individual's
25 employers.

26 J. Nothing in this Section shall be deemed to interfere

1 with the disclosure of certain records as provided for in
2 Section 1706 or with the right to make available to the
3 Internal Revenue Service of the United States Department of the
4 Treasury, or the Department of Revenue of the State of
5 Illinois, information obtained under this Act.

6 K. The Department shall make available to the Illinois
7 Student Assistance Commission, upon request, information in
8 the possession of the Department that may be necessary or
9 useful to the Commission in the collection of defaulted or
10 delinquent student loans which the Commission administers.

11 L. The Department shall make available to the State
12 Employees' Retirement System, the State Universities
13 Retirement System, the Teachers' Retirement System of the State
14 of Illinois, and the Department of Central Management Services,
15 Risk Management Division, upon request, information in the
16 possession of the Department that may be necessary or useful to
17 the System or the Risk Management Division for the purpose of
18 determining whether any recipient of a disability benefit from
19 the System or a workers' compensation benefit from the Risk
20 Management Division is gainfully employed.

21 M. This Section shall be applicable to the information
22 obtained in the administration of the State employment service,
23 except that the Director may publish or release general labor
24 market information and may furnish information that he may deem
25 proper to an individual, public officer or public agency of
26 this or any other State or the federal government (in addition

1 to those public officers or public agencies specified in this
2 Section) as he prescribes by Rule.

3 N. The Director may require such safeguards as he deems
4 proper to insure that information disclosed pursuant to this
5 Section is used only for the purposes set forth in this
6 Section.

7 O. Nothing in this Section prohibits communication with an
8 individual or entity through unencrypted e-mail or other
9 unencrypted electronic means as long as the communication does
10 not contain the individual's or entity's name in combination
11 with any one or more of the individual's or entity's social
12 security number; driver's license or State identification
13 number; account number or credit or debit card number; or any
14 required security code, access code, or password that would
15 permit access to further information pertaining to the
16 individual or entity.

17 P. Within 30 days after the effective date of this
18 amendatory Act of 1993 and annually thereafter, the Department
19 shall provide to the Department of Financial Institutions a
20 list of individuals or entities that, for the most recently
21 completed calendar year, report to the Department as paying
22 wages to workers. The lists shall be deemed confidential and
23 may not be disclosed to any other person.

24 Q. The Director shall make available to an elected federal
25 official the name and address of an individual or entity that
26 is located within the jurisdiction from which the official was

1 elected and that, for the most recently completed calendar
2 year, has reported to the Department as paying wages to
3 workers, where the information will be used in connection with
4 the official duties of the official and the official requests
5 the information in writing, specifying the purposes for which
6 it will be used. For purposes of this subsection, the use of
7 information in connection with the official duties of an
8 official does not include use of the information in connection
9 with the solicitation of contributions or expenditures, in
10 money or in kind, to or on behalf of a candidate for public or
11 political office or a political party or with respect to a
12 public question, as defined in Section 1-3 of the Election
13 Code, or in connection with any commercial solicitation. Any
14 elected federal official who, in submitting a request for
15 information covered by this subsection, knowingly makes a false
16 statement or fails to disclose a material fact, with the intent
17 to obtain the information for a purpose not authorized by this
18 subsection, shall be guilty of a Class B misdemeanor.

19 R. The Director may provide to any State or local child
20 support agency, upon request and on a reimbursable basis,
21 information that might be useful in locating an absent parent
22 or that parent's employer, establishing paternity, or
23 establishing, modifying, or enforcing child support orders.

24 S. The Department shall make available to a State's
25 Attorney of this State or a State's Attorney's investigator,
26 upon request, the current address or, if the current address is

1 unavailable, current employer information, if available, of a
2 victim of a felony or a witness to a felony or a person against
3 whom an arrest warrant is outstanding.

4 T. The Director shall make available to the Department of
5 State Police, a county sheriff's office, or a municipal police
6 department, upon request, any information concerning the
7 current address and place of employment or former places of
8 employment of a person who is required to register as a sex
9 offender under the Sex Offender Registration Act that may be
10 useful in enforcing the registration provisions of that Act.

11 U. The Director shall make information available to the
12 Department of Healthcare and Family Services and the Department
13 of Human Services for the purpose of determining eligibility
14 for public benefit programs authorized under the Illinois
15 Public Aid Code and related statutes administered by those
16 departments, for verifying sources and amounts of income, and
17 for other purposes directly connected with the administration
18 of those programs.

19 (Source: P.A. 96-420, eff. 8-13-09; 97-621, eff. 11-18-11.)

20 Section 905. The State Comptroller Act is amended by
21 changing Section 10.05 as follows:

22 (15 ILCS 405/10.05) (from Ch. 15, par. 210.05)

23 Sec. 10.05. Deductions from warrants; statement of reason
24 for deduction. Whenever any person shall be entitled to a

1 warrant or other payment from the treasury or other funds held
2 by the State Treasurer, on any account, against whom there
3 shall be any then due and payable account or claim in favor of
4 the State, the United States upon certification by the
5 Secretary of the Treasury of the United States, or his or her
6 delegate, pursuant to a reciprocal offset agreement under
7 subsection (i-1) of Section 10 of the Illinois State Collection
8 Act of 1986, or a unit of local government, a school district,
9 or a public institution of higher education, as defined in
10 Section 1 of the Board of Higher Education Act, upon
11 certification by that entity, the Comptroller, upon
12 notification thereof, shall ascertain the amount due and
13 payable to the State, the United States, the unit of local
14 government, the school district, or the public institution of
15 higher education, as aforesaid, and draw a warrant on the
16 treasury or on other funds held by the State Treasurer, stating
17 the amount for which the party was entitled to a warrant or
18 other payment, the amount deducted therefrom, and on what
19 account, and directing the payment of the balance; which
20 warrant or payment as so drawn shall be entered on the books of
21 the Treasurer, and such balance only shall be paid. The
22 Comptroller may deduct any one or more of the following: (i)
23 the entire amount due and payable to the State or a portion of
24 the amount due and payable to the State in accordance with the
25 request of the notifying agency; (ii) the entire amount due and
26 payable to the United States or a portion of the amount due and

1 payable to the United States in accordance with a reciprocal
2 offset agreement under subsection (i-1) of Section 10 of the
3 Illinois State Collection Act of 1986; or (iii) the entire
4 amount due and payable to the unit of local government, school
5 district, or public institution of higher education or a
6 portion of the amount due and payable to that entity in
7 accordance with an intergovernmental agreement authorized
8 under this Section and Section 10.05d. No request from a
9 notifying agency, the Secretary of the Treasury of the United
10 States, a unit of local government, a school district, or a
11 public institution of higher education for an amount to be
12 deducted under this Section from a wage or salary payment, or
13 from a contractual payment to an individual for personal
14 services, shall exceed 25% of the net amount of such payment.
15 "Net amount" means that part of the earnings of an individual
16 remaining after deduction of any amounts required by law to be
17 withheld. For purposes of this provision, wage, salary or other
18 payments for personal services shall not include final
19 compensation payments for the value of accrued vacation,
20 overtime or sick leave. Whenever the Comptroller draws a
21 warrant or makes a payment involving a deduction ordered under
22 this Section, the Comptroller shall notify the payee and the
23 State agency that submitted the voucher of the reason for the
24 deduction and he or she shall retain a record of such statement
25 in his or her records. As used in this Section, an "account or
26 claim in favor of the State" includes all amounts owing to

1 "State agencies" as defined in Section 7 of this Act. However,
2 the Comptroller shall not be required to accept accounts or
3 claims owing to funds not held by the State Treasurer, where
4 such accounts or claims do not exceed \$50, nor shall the
5 Comptroller deduct from funds held by the State Treasurer under
6 the Senior Citizens and Disabled Persons Property Tax Relief
7 ~~and Pharmaceutical Assistance~~ Act or for payments to
8 institutions from the Illinois Prepaid Tuition Trust Fund
9 (unless the Trust Fund moneys are used for child support). The
10 Comptroller and the Department of Revenue shall enter into an
11 interagency agreement to establish responsibilities, duties,
12 and procedures relating to deductions from lottery prizes
13 awarded under Section 20.1 of the Illinois Lottery Law. The
14 Comptroller may enter into an intergovernmental agreement with
15 the Department of Revenue and the Secretary of the Treasury of
16 the United States, or his or her delegate, to establish
17 responsibilities, duties, and procedures relating to
18 reciprocal offset of delinquent State and federal obligations
19 pursuant to subsection (i-1) of Section 10 of the Illinois
20 State Collection Act of 1986. The Comptroller may enter into
21 intergovernmental agreements with any unit of local
22 government, school district, or public institution of higher
23 education to establish responsibilities, duties, and
24 procedures to provide for the offset, by the Comptroller, of
25 obligations owed to those entities.

26 (Source: P.A. 97-269, eff. 12-16-11 (see Section 15 of P.A.

1 97-632 for the effective date of changes made by P.A. 97-269);
2 97-632, eff. 12-16-11.)

3 Section 910. The State Finance Act is amended by changing
4 Section 6z-81 as follows:

5 (30 ILCS 105/6z-81)

6 Sec. 6z-81. Healthcare Provider Relief Fund.

7 (a) There is created in the State treasury a special fund
8 to be known as the Healthcare Provider Relief 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 only as follows:

12 (1) Subject to appropriation, for payment by the
13 Department of Healthcare and Family Services or by the
14 Department of Human Services of medical bills and related
15 expenses, including administrative expenses, for which the
16 State is responsible under Titles XIX and XXI of the Social
17 Security Act, the Illinois Public Aid Code, the Children's
18 Health Insurance Program Act, the Covering ALL KIDS Health
19 Insurance Act, and the Long Term Acute Care Hospital
20 Quality Improvement Transfer Program Act. ~~and the Senior~~
21 ~~Citizens and Disabled Persons Property Tax Relief and~~
22 ~~Pharmaceutical Assistance Act.~~

23 (2) For repayment of funds borrowed from other State
24 funds or from outside sources, including interest thereon.

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

2 (1) Moneys received by the State from short-term
3 borrowing pursuant to the Short Term Borrowing Act on or
4 after the effective date of this amendatory Act of the 96th
5 General Assembly.

6 (2) All federal matching funds received by the Illinois
7 Department of Healthcare and Family Services as a result of
8 expenditures made by the Department that are attributable
9 to moneys deposited in the Fund.

10 (3) All federal matching funds received by the Illinois
11 Department of Healthcare and Family Services as a result of
12 federal approval of Title XIX State plan amendment
13 transmittal number 07-09.

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

16 (d) In addition to any other transfers that may be provided
17 for by law, on the effective date of this amendatory Act of the
18 97th General Assembly, or as soon thereafter as practical, the
19 State Comptroller shall direct and the State Treasurer shall
20 transfer the sum of \$365,000,000 from the General Revenue Fund
21 into the Healthcare Provider Relief Fund.

22 (e) In addition to any other transfers that may be provided
23 for by law, on July 1, 2011, or as soon thereafter as
24 practical, the State Comptroller shall direct and the State
25 Treasurer shall transfer the sum of \$160,000,000 from the
26 General Revenue Fund to the Healthcare Provider Relief Fund.

1 (Source: P.A. 96-820, eff. 11-18-09; 96-1100, eff. 1-1-11;
2 97-44, eff. 6-28-11; 97-641, eff. 12-19-11.)

3 Section 915. The Downstate Public Transportation Act is
4 amended by changing Sections 2-15.2 and 2-15.3 as follows:

5 (30 ILCS 740/2-15.2)

6 Sec. 2-15.2. Free services; eligibility.

7 (a) Notwithstanding any law to the contrary, no later than
8 60 days following the effective date of this amendatory Act of
9 the 95th General Assembly and until subsection (b) is
10 implemented, any fixed route public transportation services
11 provided by, or under grant or purchase of service contracts
12 of, every participant, as defined in Section 2-2.02 (1)(a),
13 shall be provided without charge to all senior citizen
14 residents of the participant aged 65 and older, under such
15 conditions as shall be prescribed by the participant.

16 (b) Notwithstanding any law to the contrary, no later than
17 180 days following the effective date of this amendatory Act of
18 the 96th General Assembly, any fixed route public
19 transportation services provided by, or under grant or purchase
20 of service contracts of, every participant, as defined in
21 Section 2-2.02 (1)(a), shall be provided without charge to
22 senior citizens aged 65 and older who meet the income
23 eligibility limitation set forth in subsection (a-5) of Section
24 4 of the Senior Citizens and Disabled Persons Property Tax

1 Relief ~~and Pharmaceutical Assistance~~ Act, under such
2 conditions as shall be prescribed by the participant. The
3 Department on Aging shall furnish all information reasonably
4 necessary to determine eligibility, including updated lists of
5 individuals who are eligible for services without charge under
6 this Section. Nothing in this Section shall relieve the
7 participant from providing reduced fares as may be required by
8 federal law.

9 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

10 (30 ILCS 740/2-15.3)

11 Sec. 2-15.3. Transit services for disabled individuals.
12 Notwithstanding any law to the contrary, no later than 60 days
13 following the effective date of this amendatory Act of the 95th
14 General Assembly, all fixed route public transportation
15 services provided by, or under grant or purchase of service
16 contract of, any participant shall be provided without charge
17 to all disabled persons who meet the income eligibility
18 limitation set forth in subsection (a-5) of Section 4 of the
19 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
20 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
21 be prescribed by the participant. The Department on Aging shall
22 furnish all information reasonably necessary to determine
23 eligibility, including updated lists of individuals who are
24 eligible for services without charge under this Section.

25 (Source: P.A. 95-906, eff. 8-26-08.)

1 Section 920. The Property Tax Code is amended by changing
2 Sections 15-172, 15-175, 20-15, and 21-27 as follows:

3 (35 ILCS 200/15-172)

4 Sec. 15-172. Senior Citizens Assessment Freeze Homestead
5 Exemption.

6 (a) This Section may be cited as the Senior Citizens
7 Assessment Freeze Homestead Exemption.

8 (b) As used in this Section:

9 "Applicant" means an individual who has filed an
10 application under this Section.

11 "Base amount" means the base year equalized assessed value
12 of the residence plus the first year's equalized assessed value
13 of any added improvements which increased the assessed value of
14 the residence after the base year.

15 "Base year" means the taxable year prior to the taxable
16 year for which the applicant first qualifies and applies for
17 the exemption provided that in the prior taxable year the
18 property was improved with a permanent structure that was
19 occupied as a residence by the applicant who was liable for
20 paying real property taxes on the property and who was either
21 (i) an owner of record of the property or had legal or
22 equitable interest in the property as evidenced by a written
23 instrument or (ii) had a legal or equitable interest as a
24 lessee in the parcel of property that was single family

1 residence. If in any subsequent taxable year for which the
2 applicant applies and qualifies for the exemption the equalized
3 assessed value of the residence is less than the equalized
4 assessed value in the existing base year (provided that such
5 equalized assessed value is not based on an assessed value that
6 results from a temporary irregularity in the property that
7 reduces the assessed value for one or more taxable years), then
8 that subsequent taxable year shall become the base year until a
9 new base year is established under the terms of this paragraph.
10 For taxable year 1999 only, the Chief County Assessment Officer
11 shall review (i) all taxable years for which the applicant
12 applied and qualified for the exemption and (ii) the existing
13 base year. The assessment officer shall select as the new base
14 year the year with the lowest equalized assessed value. An
15 equalized assessed value that is based on an assessed value
16 that results from a temporary irregularity in the property that
17 reduces the assessed value for one or more taxable years shall
18 not be considered the lowest equalized assessed value. The
19 selected year shall be the base year for taxable year 1999 and
20 thereafter until a new base year is established under the terms
21 of this paragraph.

22 "Chief County Assessment Officer" means the County
23 Assessor or Supervisor of Assessments of the county in which
24 the property is located.

25 "Equalized assessed value" means the assessed value as
26 equalized by the Illinois Department of Revenue.

1 "Household" means the applicant, the spouse of the
2 applicant, and all persons using the residence of the applicant
3 as their principal place of residence.

4 "Household income" means the combined income of the members
5 of a household for the calendar year preceding the taxable
6 year.

7 "Income" has the same meaning as provided in Section 3.07
8 of the Senior Citizens and Disabled Persons Property Tax Relief
9 ~~and Pharmaceutical Assistance Act~~, except that, beginning in
10 assessment year 2001, "income" does not include veteran's
11 benefits.

12 "Internal Revenue Code of 1986" means the United States
13 Internal Revenue Code of 1986 or any successor law or laws
14 relating to federal income taxes in effect for the year
15 preceding the taxable year.

16 "Life care facility that qualifies as a cooperative" means
17 a facility as defined in Section 2 of the Life Care Facilities
18 Act.

19 "Maximum income limitation" means:

- 20 (1) \$35,000 prior to taxable year 1999;
21 (2) \$40,000 in taxable years 1999 through 2003;
22 (3) \$45,000 in taxable years 2004 through 2005;
23 (4) \$50,000 in taxable years 2006 and 2007; and
24 (5) \$55,000 in taxable year 2008 and thereafter.

25 "Residence" means the principal dwelling place and
26 appurtenant structures used for residential purposes in this

1 State occupied on January 1 of the taxable year by a household
2 and so much of the surrounding land, constituting the parcel
3 upon which the dwelling place is situated, as is used for
4 residential purposes. If the Chief County Assessment Officer
5 has established a specific legal description for a portion of
6 property constituting the residence, then that portion of
7 property shall be deemed the residence for the purposes of this
8 Section.

9 "Taxable year" means the calendar year during which ad
10 valorem property taxes payable in the next succeeding year are
11 levied.

12 (c) Beginning in taxable year 1994, a senior citizens
13 assessment freeze homestead exemption is granted for real
14 property that is improved with a permanent structure that is
15 occupied as a residence by an applicant who (i) is 65 years of
16 age or older during the taxable year, (ii) has a household
17 income that does not exceed the maximum income limitation,
18 (iii) is liable for paying real property taxes on the property,
19 and (iv) is an owner of record of the property or has a legal or
20 equitable interest in the property as evidenced by a written
21 instrument. This homestead exemption shall also apply to a
22 leasehold interest in a parcel of property improved with a
23 permanent structure that is a single family residence that is
24 occupied as a residence by a person who (i) is 65 years of age
25 or older during the taxable year, (ii) has a household income
26 that does not exceed the maximum income limitation, (iii) has a

1 legal or equitable ownership interest in the property as
2 lessee, and (iv) is liable for the payment of real property
3 taxes on that property.

4 In counties of 3,000,000 or more inhabitants, the amount of
5 the exemption for all taxable years is the equalized assessed
6 value of the residence in the taxable year for which
7 application is made minus the base amount. In all other
8 counties, the amount of the exemption is as follows: (i)
9 through taxable year 2005 and for taxable year 2007 and
10 thereafter, the amount of this exemption shall be the equalized
11 assessed value of the residence in the taxable year for which
12 application is made minus the base amount; and (ii) for taxable
13 year 2006, the amount of the exemption is as follows:

14 (1) For an applicant who has a household income of
15 \$45,000 or less, the amount of the exemption is the
16 equalized assessed value of the residence in the taxable
17 year for which application is made minus the base amount.

18 (2) For an applicant who has a household income
19 exceeding \$45,000 but not exceeding \$46,250, the amount of
20 the exemption is (i) the equalized assessed value of the
21 residence in the taxable year for which application is made
22 minus the base amount (ii) multiplied by 0.8.

23 (3) For an applicant who has a household income
24 exceeding \$46,250 but not exceeding \$47,500, the amount of
25 the exemption is (i) the equalized assessed value of the
26 residence in the taxable year for which application is made

1 minus the base amount (ii) multiplied by 0.6.

2 (4) For an applicant who has a household income
3 exceeding \$47,500 but not exceeding \$48,750, the amount of
4 the exemption is (i) the equalized assessed value of the
5 residence in the taxable year for which application is made
6 minus the base amount (ii) multiplied by 0.4.

7 (5) For an applicant who has a household income
8 exceeding \$48,750 but not exceeding \$50,000, the amount of
9 the exemption is (i) the equalized assessed value of the
10 residence in the taxable year for which application is made
11 minus the base amount (ii) multiplied by 0.2.

12 When the applicant is a surviving spouse of an applicant
13 for a prior year for the same residence for which an exemption
14 under this Section has been granted, the base year and base
15 amount for that residence are the same as for the applicant for
16 the prior year.

17 Each year at the time the assessment books are certified to
18 the County Clerk, the Board of Review or Board of Appeals shall
19 give to the County Clerk a list of the assessed values of
20 improvements on each parcel qualifying for this exemption that
21 were added after the base year for this parcel and that
22 increased the assessed value of the property.

23 In the case of land improved with an apartment building
24 owned and operated as a cooperative or a building that is a
25 life care facility that qualifies as a cooperative, the maximum
26 reduction from the equalized assessed value of the property is

1 limited to the sum of the reductions calculated for each unit
2 occupied as a residence by a person or persons (i) 65 years of
3 age or older, (ii) with a household income that does not exceed
4 the maximum income limitation, (iii) who is liable, by contract
5 with the owner or owners of record, for paying real property
6 taxes on the property, and (iv) who is an owner of record of a
7 legal or equitable interest in the cooperative apartment
8 building, other than a leasehold interest. In the instance of a
9 cooperative where a homestead exemption has been granted under
10 this Section, the cooperative association or its management
11 firm shall credit the savings resulting from that exemption
12 only to the apportioned tax liability of the owner who
13 qualified for the exemption. Any person who willfully refuses
14 to credit that savings to an owner who qualifies for the
15 exemption is guilty of a Class B misdemeanor.

16 When a homestead exemption has been granted under this
17 Section and an applicant then becomes a resident of a facility
18 licensed under the Assisted Living and Shared Housing Act, the
19 Nursing Home Care Act, the Specialized Mental Health
20 Rehabilitation Act, or the ID/DD Community Care Act, the
21 exemption shall be granted in subsequent years so long as the
22 residence (i) continues to be occupied by the qualified
23 applicant's spouse or (ii) if remaining unoccupied, is still
24 owned by the qualified applicant for the homestead exemption.

25 Beginning January 1, 1997, when an individual dies who
26 would have qualified for an exemption under this Section, and

1 the surviving spouse does not independently qualify for this
2 exemption because of age, the exemption under this Section
3 shall be granted to the surviving spouse for the taxable year
4 preceding and the taxable year of the death, provided that,
5 except for age, the surviving spouse meets all other
6 qualifications for the granting of this exemption for those
7 years.

8 When married persons maintain separate residences, the
9 exemption provided for in this Section may be claimed by only
10 one of such persons and for only one residence.

11 For taxable year 1994 only, in counties having less than
12 3,000,000 inhabitants, to receive the exemption, a person shall
13 submit an application by February 15, 1995 to the Chief County
14 Assessment Officer of the county in which the property is
15 located. In counties having 3,000,000 or more inhabitants, for
16 taxable year 1994 and all subsequent taxable years, to receive
17 the exemption, a person may submit an application to the Chief
18 County Assessment Officer of the county in which the property
19 is located during such period as may be specified by the Chief
20 County Assessment Officer. The Chief County Assessment Officer
21 in counties of 3,000,000 or more inhabitants shall annually
22 give notice of the application period by mail or by
23 publication. In counties having less than 3,000,000
24 inhabitants, beginning with taxable year 1995 and thereafter,
25 to receive the exemption, a person shall submit an application
26 by July 1 of each taxable year to the Chief County Assessment

1 Officer of the county in which the property is located. A
2 county may, by ordinance, establish a date for submission of
3 applications that is different than July 1. The applicant shall
4 submit with the application an affidavit of the applicant's
5 total household income, age, marital status (and if married the
6 name and address of the applicant's spouse, if known), and
7 principal dwelling place of members of the household on January
8 1 of the taxable year. The Department shall establish, by rule,
9 a method for verifying the accuracy of affidavits filed by
10 applicants under this Section, and the Chief County Assessment
11 Officer may conduct audits of any taxpayer claiming an
12 exemption under this Section to verify that the taxpayer is
13 eligible to receive the exemption. Each application shall
14 contain or be verified by a written declaration that it is made
15 under the penalties of perjury. A taxpayer's signing a
16 fraudulent application under this Act is perjury, as defined in
17 Section 32-2 of the Criminal Code of 1961. The applications
18 shall be clearly marked as applications for the Senior Citizens
19 Assessment Freeze Homestead Exemption and must contain a notice
20 that any taxpayer who receives the exemption is subject to an
21 audit by the Chief County Assessment Officer.

22 Notwithstanding any other provision to the contrary, in
23 counties having fewer than 3,000,000 inhabitants, if an
24 applicant fails to file the application required by this
25 Section in a timely manner and this failure to file is due to a
26 mental or physical condition sufficiently severe so as to

1 render the applicant incapable of filing the application in a
2 timely manner, the Chief County Assessment Officer may extend
3 the filing deadline for a period of 30 days after the applicant
4 regains the capability to file the application, but in no case
5 may the filing deadline be extended beyond 3 months of the
6 original filing deadline. In order to receive the extension
7 provided in this paragraph, the applicant shall provide the
8 Chief County Assessment Officer with a signed statement from
9 the applicant's physician stating the nature and extent of the
10 condition, that, in the physician's opinion, the condition was
11 so severe that it rendered the applicant incapable of filing
12 the application in a timely manner, and the date on which the
13 applicant regained the capability to file the application.

14 Beginning January 1, 1998, notwithstanding any other
15 provision to the contrary, in counties having fewer than
16 3,000,000 inhabitants, if an applicant fails to file the
17 application required by this Section in a timely manner and
18 this failure to file is due to a mental or physical condition
19 sufficiently severe so as to render the applicant incapable of
20 filing the application in a timely manner, the Chief County
21 Assessment Officer may extend the filing deadline for a period
22 of 3 months. In order to receive the extension provided in this
23 paragraph, the applicant shall provide the Chief County
24 Assessment Officer with a signed statement from the applicant's
25 physician stating the nature and extent of the condition, and
26 that, in the physician's opinion, the condition was so severe

1 that it rendered the applicant incapable of filing the
2 application in a timely manner.

3 In counties having less than 3,000,000 inhabitants, if an
4 applicant was denied an exemption in taxable year 1994 and the
5 denial occurred due to an error on the part of an assessment
6 official, or his or her agent or employee, then beginning in
7 taxable year 1997 the applicant's base year, for purposes of
8 determining the amount of the exemption, shall be 1993 rather
9 than 1994. In addition, in taxable year 1997, the applicant's
10 exemption shall also include an amount equal to (i) the amount
11 of any exemption denied to the applicant in taxable year 1995
12 as a result of using 1994, rather than 1993, as the base year,
13 (ii) the amount of any exemption denied to the applicant in
14 taxable year 1996 as a result of using 1994, rather than 1993,
15 as the base year, and (iii) the amount of the exemption
16 erroneously denied for taxable year 1994.

17 For purposes of this Section, a person who will be 65 years
18 of age during the current taxable year shall be eligible to
19 apply for the homestead exemption during that taxable year.
20 Application shall be made during the application period in
21 effect for the county of his or her residence.

22 The Chief County Assessment Officer may determine the
23 eligibility of a life care facility that qualifies as a
24 cooperative to receive the benefits provided by this Section by
25 use of an affidavit, application, visual inspection,
26 questionnaire, or other reasonable method in order to insure

1 that the tax savings resulting from the exemption are credited
2 by the management firm to the apportioned tax liability of each
3 qualifying resident. The Chief County Assessment Officer may
4 request reasonable proof that the management firm has so
5 credited that exemption.

6 Except as provided in this Section, all information
7 received by the chief county assessment officer or the
8 Department from applications filed under this Section, or from
9 any investigation conducted under the provisions of this
10 Section, shall be confidential, except for official purposes or
11 pursuant to official procedures for collection of any State or
12 local tax or enforcement of any civil or criminal penalty or
13 sanction imposed by this Act or by any statute or ordinance
14 imposing a State or local tax. Any person who divulges any such
15 information in any manner, except in accordance with a proper
16 judicial order, is guilty of a Class A misdemeanor.

17 Nothing contained in this Section shall prevent the
18 Director or chief county assessment officer from publishing or
19 making available reasonable statistics concerning the
20 operation of the exemption contained in this Section in which
21 the contents of claims are grouped into aggregates in such a
22 way that information contained in any individual claim shall
23 not be disclosed.

24 (d) Each Chief County Assessment Officer shall annually
25 publish a notice of availability of the exemption provided
26 under this Section. The notice shall be published at least 60

1 days but no more than 75 days prior to the date on which the
2 application must be submitted to the Chief County Assessment
3 Officer of the county in which the property is located. The
4 notice shall appear in a newspaper of general circulation in
5 the county.

6 Notwithstanding Sections 6 and 8 of the State Mandates Act,
7 no reimbursement by the State is required for the
8 implementation of any mandate created by this Section.

9 (Source: P.A. 96-339, eff. 7-1-10; 96-355, eff. 1-1-10;
10 96-1000, eff. 7-2-10; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12;
11 revised 9-12-11.)

12 (35 ILCS 200/15-175)

13 Sec. 15-175. General homestead exemption. Except as
14 provided in Sections 15-176 and 15-177, homestead property is
15 entitled to an annual homestead exemption limited, except as
16 described here with relation to cooperatives, to a reduction in
17 the equalized assessed value of homestead property equal to the
18 increase in equalized assessed value for the current assessment
19 year above the equalized assessed value of the property for
20 1977, up to the maximum reduction set forth below. If however,
21 the 1977 equalized assessed value upon which taxes were paid is
22 subsequently determined by local assessing officials, the
23 Property Tax Appeal Board, or a court to have been excessive,
24 the equalized assessed value which should have been placed on
25 the property for 1977 shall be used to determine the amount of

1 the exemption.

2 Except as provided in Section 15-176, the maximum reduction
3 before taxable year 2004 shall be \$4,500 in counties with
4 3,000,000 or more inhabitants and \$3,500 in all other counties.
5 Except as provided in Sections 15-176 and 15-177, for taxable
6 years 2004 through 2007, the maximum reduction shall be \$5,000,
7 for taxable year 2008, the maximum reduction is \$5,500, and,
8 for taxable years 2009 and thereafter, the maximum reduction is
9 \$6,000 in all counties. If a county has elected to subject
10 itself to the provisions of Section 15-176 as provided in
11 subsection (k) of that Section, then, for the first taxable
12 year only after the provisions of Section 15-176 no longer
13 apply, for owners who, for the taxable year, have not been
14 granted a senior citizens assessment freeze homestead
15 exemption under Section 15-172 or a long-time occupant
16 homestead exemption under Section 15-177, there shall be an
17 additional exemption of \$5,000 for owners with a household
18 income of \$30,000 or less.

19 In counties with fewer than 3,000,000 inhabitants, if,
20 based on the most recent assessment, the equalized assessed
21 value of the homestead property for the current assessment year
22 is greater than the equalized assessed value of the property
23 for 1977, the owner of the property shall automatically receive
24 the exemption granted under this Section in an amount equal to
25 the increase over the 1977 assessment up to the maximum
26 reduction set forth in this Section.

1 If in any assessment year beginning with the 2000
2 assessment year, homestead property has a pro-rata valuation
3 under Section 9-180 resulting in an increase in the assessed
4 valuation, a reduction in equalized assessed valuation equal to
5 the increase in equalized assessed value of the property for
6 the year of the pro-rata valuation above the equalized assessed
7 value of the property for 1977 shall be applied to the property
8 on a proportionate basis for the period the property qualified
9 as homestead property during the assessment year. The maximum
10 proportionate homestead exemption shall not exceed the maximum
11 homestead exemption allowed in the county under this Section
12 divided by 365 and multiplied by the number of days the
13 property qualified as homestead property.

14 "Homestead property" under this Section includes
15 residential property that is occupied by its owner or owners as
16 his or their principal dwelling place, or that is a leasehold
17 interest on which a single family residence is situated, which
18 is occupied as a residence by a person who has an ownership
19 interest therein, legal or equitable or as a lessee, and on
20 which the person is liable for the payment of property taxes.
21 For land improved with an apartment building owned and operated
22 as a cooperative or a building which is a life care facility as
23 defined in Section 15-170 and considered to be a cooperative
24 under Section 15-170, the maximum reduction from the equalized
25 assessed value shall be limited to the increase in the value
26 above the equalized assessed value of the property for 1977, up

1 to the maximum reduction set forth above, multiplied by the
2 number of apartments or units occupied by a person or persons
3 who is liable, by contract with the owner or owners of record,
4 for paying property taxes on the property and is an owner of
5 record of a legal or equitable interest in the cooperative
6 apartment building, other than a leasehold interest. For
7 purposes of this Section, the term "life care facility" has the
8 meaning stated in Section 15-170.

9 "Household", as used in this Section, means the owner, the
10 spouse of the owner, and all persons using the residence of the
11 owner as their principal place of residence.

12 "Household income", as used in this Section, means the
13 combined income of the members of a household for the calendar
14 year preceding the taxable year.

15 "Income", as used in this Section, has the same meaning as
16 provided in Section 3.07 of the Senior Citizens and Disabled
17 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act,
18 except that "income" does not include veteran's benefits.

19 In a cooperative where a homestead exemption has been
20 granted, the cooperative association or its management firm
21 shall credit the savings resulting from that exemption only to
22 the apportioned tax liability of the owner who qualified for
23 the exemption. Any person who willfully refuses to so credit
24 the savings shall be guilty of a Class B misdemeanor.

25 Where married persons maintain and reside in separate
26 residences qualifying as homestead property, each residence

1 shall receive 50% of the total reduction in equalized assessed
2 valuation provided by this Section.

3 In all counties, the assessor or chief county assessment
4 officer may determine the eligibility of residential property
5 to receive the homestead exemption and the amount of the
6 exemption by application, visual inspection, questionnaire or
7 other reasonable methods. The determination shall be made in
8 accordance with guidelines established by the Department,
9 provided that the taxpayer applying for an additional general
10 exemption under this Section shall submit to the chief county
11 assessment officer an application with an affidavit of the
12 applicant's total household income, age, marital status (and,
13 if married, the name and address of the applicant's spouse, if
14 known), and principal dwelling place of members of the
15 household on January 1 of the taxable year. The Department
16 shall issue guidelines establishing a method for verifying the
17 accuracy of the affidavits filed by applicants under this
18 paragraph. The applications shall be clearly marked as
19 applications for the Additional General Homestead Exemption.

20 In counties with fewer than 3,000,000 inhabitants, in the
21 event of a sale of homestead property the homestead exemption
22 shall remain in effect for the remainder of the assessment year
23 of the sale. The assessor or chief county assessment officer
24 may require the new owner of the property to apply for the
25 homestead exemption for the following assessment year.

26 Notwithstanding Sections 6 and 8 of the State Mandates Act,

1 no reimbursement by the State is required for the
2 implementation of any mandate created by this Section.

3 (Source: P.A. 95-644, eff. 10-12-07.)

4 (35 ILCS 200/20-15)

5 Sec. 20-15. Information on bill or separate statement.
6 There shall be printed on each bill, or on a separate slip
7 which shall be mailed with the bill:

8 (a) a statement itemizing the rate at which taxes have
9 been extended for each of the taxing districts in the
10 county in whose district the property is located, and in
11 those counties utilizing electronic data processing
12 equipment the dollar amount of tax due from the person
13 assessed allocable to each of those taxing districts,
14 including a separate statement of the dollar amount of tax
15 due which is allocable to a tax levied under the Illinois
16 Local Library Act or to any other tax levied by a
17 municipality or township for public library purposes,

18 (b) a separate statement for each of the taxing
19 districts of the dollar amount of tax due which is
20 allocable to a tax levied under the Illinois Pension Code
21 or to any other tax levied by a municipality or township
22 for public pension or retirement purposes,

23 (c) the total tax rate,

24 (d) the total amount of tax due, and

25 (e) the amount by which the total tax and the tax

1 allocable to each taxing district differs from the
2 taxpayer's last prior tax bill.

3 The county treasurer shall ensure that only those taxing
4 districts in which a parcel of property is located shall be
5 listed on the bill for that property.

6 In all counties the statement shall also provide:

7 (1) the property index number or other suitable
8 description,

9 (2) the assessment of the property,

10 (3) the equalization factors imposed by the county and
11 by the Department, and

12 (4) the equalized assessment resulting from the
13 application of the equalization factors to the basic
14 assessment.

15 In all counties which do not classify property for purposes
16 of taxation, for property on which a single family residence is
17 situated the statement shall also include a statement to
18 reflect the fair cash value determined for the property. In all
19 counties which classify property for purposes of taxation in
20 accordance with Section 4 of Article IX of the Illinois
21 Constitution, for parcels of residential property in the lowest
22 assessment classification the statement shall also include a
23 statement to reflect the fair cash value determined for the
24 property.

25 In all counties, the statement must include information
26 that certain taxpayers may be eligible for tax exemptions,

1 abatement, and other assistance programs and that, for more
2 information, taxpayers should consult with the office of their
3 township or county assessor and with the Illinois Department of
4 Revenue.

5 In all counties, the statement shall include information
6 that certain taxpayers may be eligible for the Senior Citizens
7 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
8 ~~Assistance~~ Act and that applications are available from the
9 Illinois Department on Aging.

10 In counties which use the estimated or accelerated billing
11 methods, these statements shall only be provided with the final
12 installment of taxes due. The provisions of this Section create
13 a mandatory statutory duty. They are not merely directory or
14 discretionary. The failure or neglect of the collector to mail
15 the bill, or the failure of the taxpayer to receive the bill,
16 shall not affect the validity of any tax, or the liability for
17 the payment of any tax.

18 (Source: P.A. 95-644, eff. 10-12-07.)

19 (35 ILCS 200/21-27)

20 Sec. 21-27. Waiver of interest penalty.

21 (a) On the recommendation of the county treasurer, the
22 county board may adopt a resolution under which an interest
23 penalty for the delinquent payment of taxes for any year that
24 otherwise would be imposed under Section 21-15, 21-20, or 21-25
25 shall be waived in the case of any person who meets all of the

1 following criteria:

2 (1) The person is determined eligible for a grant under
3 the Senior Citizens and Disabled Persons Property Tax
4 Relief ~~and Pharmaceutical Assistance~~ Act with respect to
5 the taxes for that year.

6 (2) The person requests, in writing, on a form approved
7 by the county treasurer, a waiver of the interest penalty,
8 and the request is filed with the county treasurer on or
9 before the first day of the month that an installment of
10 taxes is due.

11 (3) The person pays the installment of taxes due, in
12 full, on or before the third day of the month that the
13 installment is due.

14 (4) The county treasurer approves the request for a
15 waiver.

16 (b) With respect to property that qualifies as a brownfield
17 site under Section 58.2 of the Environmental Protection Act,
18 the county board, upon the recommendation of the county
19 treasurer, may adopt a resolution to waive an interest penalty
20 for the delinquent payment of taxes for any year that otherwise
21 would be imposed under Section 21-15, 21-20, or 21-25 if all of
22 the following criteria are met:

23 (1) the property has delinquent taxes and an
24 outstanding interest penalty and the amount of that
25 interest penalty is so large as to, possibly, result in all
26 of the taxes becoming uncollectible;

1 (2) the property is part of a redevelopment plan of a
2 unit of local government and that unit of local government
3 does not oppose the waiver of the interest penalty;

4 (3) the redevelopment of the property will benefit the
5 public interest by remediating the brownfield
6 contamination;

7 (4) the taxpayer delivers to the county treasurer (i) a
8 written request for a waiver of the interest penalty, on a
9 form approved by the county treasurer, and (ii) a copy of
10 the redevelopment plan for the property;

11 (5) the taxpayer pays, in full, the amount of up to the
12 amount of the first 2 installments of taxes due, to be held
13 in escrow pending the approval of the waiver, and enters
14 into an agreement with the county treasurer setting forth a
15 schedule for the payment of any remaining taxes due; and

16 (6) the county treasurer approves the request for a
17 waiver.

18 (Source: P.A. 97-655, eff. 1-13-12.)

19 Section 925. The Mobile Home Local Services Tax Act is
20 amended by changing Section 7 as follows:

21 (35 ILCS 515/7) (from Ch. 120, par. 1207)

22 Sec. 7. The local services tax for owners of mobile homes
23 who (a) are actually residing in such mobile homes, (b) hold
24 title to such mobile home as provided in the Illinois Vehicle

1 Code, and (c) are 65 years of age or older or are disabled
2 persons within the meaning of Section 3.14 of the "Senior
3 Citizens and Disabled Persons Property Tax Relief ~~and~~
4 ~~Pharmaceutical Assistance Act~~" on the annual billing date shall
5 be reduced to 80 percent of the tax provided for in Section 3
6 of this Act. Proof that a claimant has been issued an Illinois
7 Disabled Person Identification Card stating that the claimant
8 is under a Class 2 disability, as provided in Section 4A of the
9 Illinois Identification Card Act, shall constitute proof that
10 the person thereon named is a disabled person within the
11 meaning of this Act. An application for reduction of the tax
12 shall be filed with the county clerk by the individuals who are
13 entitled to the reduction. If the application is filed after
14 May 1, the reduction in tax shall begin with the next annual
15 bill. Application for the reduction in tax shall be done by
16 submitting proof that the applicant has been issued an Illinois
17 Disabled Person Identification Card designating the
18 applicant's disability as a Class 2 disability, or by affidavit
19 in substantially the following form:

20 APPLICATION FOR REDUCTION OF MOBILE HOME LOCAL SERVICES TAX

21 I hereby make application for a reduction to 80% of the
22 total tax imposed under "An Act to provide for a local services
23 tax on mobile homes".

24 (1) Senior Citizens

25 (a) I actually reside in the mobile home

26 (b) I hold title to the mobile home as provided in the

1 Illinois Vehicle Code

2 (c) I reached the age of 65 on or before either January 1
3 (or July 1) of the year in which this statement is filed. My
4 date of birth is: ...

5 (2) Disabled Persons

6 (a) I actually reside in the mobile home...

7 (b) I hold title to the mobile home as provided in the
8 Illinois Vehicle Code

9 (c) I was totally disabled on ... and have remained
10 disabled until the date of this application. My Social
11 Security, Veterans, Railroad or Civil Service Total Disability
12 Claim Number is ... The undersigned declares under the penalty
13 of perjury that the above statements are true and correct.

14 Dated (insert date).

15

16 Signature of owner

17

18 (Address)

19

20 (City) (State) (Zip)

21 Approved by:

22

23 (Assessor)

24 This application shall be accompanied by a copy of the
25 applicant's most recent application filed with the Illinois

1 Department on Aging under the Senior Citizens and Disabled
2 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.
3 (Source: P.A. 96-804, eff. 1-1-10.)

4 Section 930. The Metropolitan Transit Authority Act is
5 amended by changing Sections 51 and 52 as follows:

6 (70 ILCS 3605/51)

7 Sec. 51. 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 Board shall be provided without charge to all senior
14 citizens of the Metropolitan Region (as such term is defined in
15 70 ILCS 3615/1.03) aged 65 and older, under such conditions as
16 shall be prescribed by the 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 Board shall be provided without
22 charge to senior citizens aged 65 and older who meet the income
23 eligibility limitation set forth in subsection (a-5) of Section
24 4 of the Senior Citizens and Disabled Persons Property Tax

1 Relief ~~and Pharmaceutical Assistance~~ Act, under such
2 conditions as shall be prescribed by the Board. The Department
3 on Aging shall furnish all information reasonably necessary to
4 determine eligibility, including updated lists of individuals
5 who are eligible for services without charge under this
6 Section. Nothing in this Section shall relieve the Board from
7 providing 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 3605/52)

10 Sec. 52. 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 Board shall be provided without charge to all
16 disabled persons who meet the income eligibility limitation set
17 forth in subsection (a-5) of Section 4 of the Senior Citizens
18 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
19 ~~Assistance~~ Act, under such procedures as shall be prescribed by
20 the Board. The Department on Aging shall furnish all
21 information reasonably necessary to determine eligibility,
22 including updated lists of individuals who are eligible for
23 services without charge under this Section.

24 (Source: P.A. 95-906, eff. 8-26-08.)

1 Section 935. The Local Mass Transit District Act is amended
2 by changing Sections 8.6 and 8.7 as follows:

3 (70 ILCS 3610/8.6)

4 Sec. 8.6. Free services; eligibility.

5 (a) Notwithstanding any law to the contrary, no later than
6 60 days following the effective date of this amendatory Act of
7 the 95th General Assembly and until subsection (b) is
8 implemented, any fixed route public transportation services
9 provided by, or under grant or purchase of service contracts
10 of, every District shall be provided without charge to all
11 senior citizens of the District aged 65 and older, under such
12 conditions as shall be prescribed by the District.

13 (b) Notwithstanding any law to the contrary, no later than
14 180 days following the effective date of this amendatory Act of
15 the 96th General Assembly, any fixed route public
16 transportation services provided by, or under grant or purchase
17 of service contracts of, every District shall be provided
18 without charge to senior citizens aged 65 and older who meet
19 the income eligibility limitation set forth in subsection (a-5)
20 of Section 4 of the Senior Citizens and Disabled Persons
21 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under
22 such conditions as shall be prescribed by the District. The
23 Department on Aging shall furnish all information reasonably
24 necessary to determine eligibility, including updated lists of
25 individuals who are eligible for services without charge under

1 this Section. Nothing in this Section shall relieve the
2 District from providing reduced fares as may be required by
3 federal law.

4 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

5 (70 ILCS 3610/8.7)

6 Sec. 8.7. Transit services for disabled individuals.
7 Notwithstanding any law to the contrary, no later than 60 days
8 following the effective date of this amendatory Act of the 95th
9 General Assembly, all fixed route public transportation
10 services provided by, or under grant or purchase of service
11 contract of, any District shall be provided without charge to
12 all disabled persons who meet the income eligibility limitation
13 set forth in subsection (a-5) of Section 4 of the Senior
14 Citizens and Disabled Persons Property Tax Relief ~~and~~
15 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
16 be prescribed by the District. The Department on Aging shall
17 furnish all information reasonably necessary to determine
18 eligibility, including updated lists of individuals who are
19 eligible for services without charge under this Section.

20 (Source: P.A. 95-906, eff. 8-26-08.)

21 Section 940. The Regional Transportation Authority Act is
22 amended by changing Sections 3A.15, 3A.16, 3B.14, and 3B.15 as
23 follows:

1 (70 ILCS 3615/3A.15)

2 Sec. 3A.15. Free services; eligibility.

3 (a) Notwithstanding any law to the contrary, no later than
4 60 days following the effective date of this amendatory Act of
5 the 95th General Assembly and until subsection (b) is
6 implemented, any fixed route public transportation services
7 provided by, or under grant or purchase of service contracts
8 of, the Suburban Bus Board shall be provided without charge to
9 all senior citizens of the Metropolitan Region aged 65 and
10 older, under such conditions as shall be prescribed by the
11 Suburban Bus Board.

12 (b) Notwithstanding any law to the contrary, no later than
13 180 days following the effective date of this amendatory Act of
14 the 96th General Assembly, any fixed route public
15 transportation services provided by, or under grant or purchase
16 of service contracts of, the Suburban Bus Board shall be
17 provided without charge to senior citizens aged 65 and older
18 who meet the income eligibility limitation set forth in
19 subsection (a-5) of Section 4 of the Senior Citizens and
20 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
21 ~~Assistance~~ Act, under such conditions as shall be prescribed by
22 the Suburban Bus Board. The Department on Aging shall furnish
23 all information reasonably necessary to determine eligibility,
24 including updated lists of individuals who are eligible for
25 services without charge under this Section. Nothing in this
26 Section shall relieve the Suburban Bus Board from providing

1 reduced fares as may be required by federal law.

2 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

3 (70 ILCS 3615/3A.16)

4 Sec. 3A.16. Transit services for disabled individuals.

5 Notwithstanding any law to the contrary, no later than 60 days
6 following the effective date of this amendatory Act of the 95th
7 General Assembly, all fixed route public transportation
8 services provided by, or under grant or purchase of service
9 contract of, the Suburban Bus Board shall be provided without
10 charge to all disabled persons who meet the income eligibility
11 limitation set forth in subsection (a-5) of Section 4 of the
12 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
13 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
14 be prescribed by the Board. The Department on Aging shall
15 furnish all information reasonably necessary to determine
16 eligibility, including updated lists of individuals who are
17 eligible for services without charge under this Section.

18 (Source: P.A. 95-906, eff. 8-26-08.)

19 (70 ILCS 3615/3B.14)

20 Sec. 3B.14. Free services; eligibility.

21 (a) Notwithstanding any law to the contrary, no later than
22 60 days following the effective date of this amendatory Act of
23 the 95th General Assembly and until subsection (b) is
24 implemented, any fixed route public transportation services

1 provided by, or under grant or purchase of service contracts
2 of, the Commuter Rail Board shall be provided without charge to
3 all senior citizens of the Metropolitan Region aged 65 and
4 older, under such conditions as shall be prescribed by the
5 Commuter Rail Board.

6 (b) Notwithstanding any law to the contrary, no later than
7 180 days following the effective date of this amendatory Act of
8 the 96th General Assembly, any fixed route public
9 transportation services provided by, or under grant or purchase
10 of service contracts of, the Commuter Rail Board shall be
11 provided without charge to senior citizens aged 65 and older
12 who meet the income eligibility limitation set forth in
13 subsection (a-5) of Section 4 of the Senior Citizens and
14 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
15 ~~Assistance~~ Act, under such conditions as shall be prescribed by
16 the Commuter Rail Board. The Department on Aging shall furnish
17 all information reasonably necessary to determine eligibility,
18 including updated lists of individuals who are eligible for
19 services without charge under this Section. Nothing in this
20 Section shall relieve the Commuter Rail Board from providing
21 reduced fares as may be required by federal law.

22 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

23 (70 ILCS 3615/3B.15)

24 Sec. 3B.15. Transit services for disabled individuals.
25 Notwithstanding any law to the contrary, no later than 60 days

1 following the effective date of this amendatory Act of the 95th
2 General Assembly, all fixed route public transportation
3 services provided by, or under grant or purchase of service
4 contract of, the Commuter Rail Board shall be provided without
5 charge to all disabled persons who meet the income eligibility
6 limitation set forth in subsection (a-5) of Section 4 of the
7 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
8 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
9 be prescribed by the Board. The Department on Aging shall
10 furnish all information reasonably necessary to determine
11 eligibility, including updated lists of individuals who are
12 eligible for services without charge under this Section.

13 (Source: P.A. 95-906, eff. 8-26-08.)

14 Section 945. The Senior Citizen Courses Act is amended by
15 changing Section 1 as follows:

16 (110 ILCS 990/1) (from Ch. 144, par. 1801)

17 Sec. 1. Definitions. For the purposes of this Act:

18 (a) "Public institutions of higher education" means the
19 University of Illinois, Southern Illinois University, Chicago
20 State University, Eastern Illinois University, Governors State
21 University, Illinois State University, Northeastern Illinois
22 University, Northern Illinois University, Western Illinois
23 University, and the public community colleges subject to the
24 "Public Community College Act".

1 (b) "Credit Course" means any program of study for which
2 public institutions of higher education award credit hours.

3 (c) "Senior citizen" means any person 65 years or older
4 whose annual household income is less than the threshold amount
5 provided in Section 4 of the "Senior Citizens and Disabled
6 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~
7 Act", approved July 17, 1972, as amended.

8 (Source: P.A. 89-4, eff. 1-1-96.)

9 Section 950. The Citizens Utility Board Act is amended by
10 changing Section 9 as follows:

11 (220 ILCS 10/9) (from Ch. 111 2/3, par. 909)

12 Sec. 9. Mailing procedure.

13 (1) As used in this Section:

14 (a) "Enclosure" means a card, leaflet, envelope or
15 combination thereof furnished by the corporation under
16 this Section.

17 (b) "Mailing" means any communication by a State
18 agency, other than a mailing made under the Senior Citizens
19 and Disabled Persons Property Tax Relief ~~and~~
20 ~~Pharmaceutical Assistance~~ Act, that is sent through the
21 United States Postal Service to more than 50,000 persons
22 within a 12-month period.

23 (c) "State agency" means any officer, department,
24 board, commission, institution or entity of the executive

1 or legislative branches of State government.

2 (2) To accomplish its powers and duties under Section 5
3 this Act, the corporation, subject to the following
4 limitations, may prepare and furnish to any State agency an
5 enclosure to be included with a mailing by that agency.

6 (a) A State agency furnished with an enclosure shall
7 include the enclosure within the mailing designated by the
8 corporation.

9 (b) An enclosure furnished by the corporation under
10 this Section shall be provided to the State agency a
11 reasonable period of time in advance of the mailing.

12 (c) An enclosure furnished by the corporation under
13 this Section shall be limited to informing the reader of
14 the purpose, nature and activities of the corporation as
15 set forth in this Act and informing the reader that it may
16 become a member in the corporation, maintain membership in
17 the corporation and contribute money to the corporation
18 directly.

19 (d) Prior to furnishing an enclosure to the State
20 agency, the corporation shall seek and obtain approval of
21 the content of the enclosure from the Illinois Commerce
22 Commission. The Commission shall approve the enclosure if
23 it determines that the enclosure (i) is not false or
24 misleading and (ii) satisfies the requirements of this Act.
25 The Commission shall be deemed to have approved the
26 enclosure unless it disapproves the enclosure within 14

1 days from the date of receipt.

2 (3) The corporation shall reimburse each State agency for
3 all reasonable incremental costs incurred by the State agency
4 in complying with this Section above the agency's normal
5 mailing and handling costs, provided that:

6 (a) The State agency shall first furnish the
7 corporation with an itemized accounting of such additional
8 cost; and

9 (b) The corporation shall not be required to reimburse
10 the State agency for postage costs if the weight of the
11 corporation's enclosure does not exceed .35 ounce
12 avoirdupois. If the corporation's enclosure exceeds that
13 weight, then it shall only be required to reimburse the
14 State agency for postage cost over and above what the
15 agency's postage cost would have been had the enclosure
16 weighed only .35 ounce avoirdupois.

17 (Source: P.A. 96-804, eff. 1-1-10.)

18 Section 955. The Illinois Public Aid Code is amended by
19 changing Sections 3-5, 4-1.6, 4-2, 6-1.2, 6-2, and 12-9 as
20 follows:

21 (305 ILCS 5/3-5) (from Ch. 23, par. 3-5)

22 Sec. 3-5. Amount of aid. The amount and nature of financial
23 aid granted to or in behalf of aged, blind, or disabled persons
24 shall be determined in accordance with the standards, grant

1 amounts, rules and regulations of the Illinois Department. Due
2 regard shall be given to the requirements and conditions
3 existing in each case, and to the amount of property owned and
4 the income, money contributions, and other support, and
5 resources received or obtainable by the person, from whatever
6 source. However, the amount and nature of any financial aid is
7 not affected by the payment of any grant under the "Senior
8 Citizens and Disabled Persons Property Tax Relief ~~and~~
9 ~~Pharmaceutical Assistance Act~~" or any distributions or items of
10 income described under subparagraph (X) of paragraph (2) of
11 subsection (a) of Section 203 of the Illinois Income Tax Act.
12 The aid shall be sufficient, when added to all other income,
13 money contributions and support, to provide the person with a
14 grant in the amount established by Department regulation for
15 such a person, based upon standards providing a livelihood
16 compatible with health and well-being. Financial aid under this
17 Article granted to persons who have been found ineligible for
18 Supplemental Security Income (SSI) due to expiration of the
19 period of eligibility for refugees and asylees pursuant to 8
20 U.S.C. 1612(a)(2) shall not exceed \$500 per month.

21 (Source: P.A. 93-741, eff. 7-15-04.)

22 (305 ILCS 5/4-1.6) (from Ch. 23, par. 4-1.6)

23 Sec. 4-1.6. Need. Income available to the family as defined
24 by the Illinois Department by rule, or to the child in the case
25 of a child removed from his or her home, when added to

1 contributions in money, substance or services from other
2 sources, including income available from parents absent from
3 the home or from a stepparent, contributions made for the
4 benefit of the parent or other persons necessary to provide
5 care and supervision to the child, and contributions from
6 legally responsible relatives, must be equal to or less than
7 the grant amount established by Department regulation for such
8 a person. For purposes of eligibility for aid under this
9 Article, the Department shall disregard all earned income
10 between the grant amount and 50% of the Federal Poverty Level.

11 In considering income to be taken into account,
12 consideration shall be given to any expenses reasonably
13 attributable to the earning of such income. Three-fourths of
14 the earned income of a household eligible for aid under this
15 Article shall be disregarded when determining the level of
16 assistance for which a household is eligible. The Illinois
17 Department may also permit all or any portion of earned or
18 other income to be set aside for the future identifiable needs
19 of a child. The Illinois Department may provide by rule and
20 regulation for the exemptions thus permitted or required. The
21 eligibility of any applicant for or recipient of public aid
22 under this Article is not affected by the payment of any grant
23 under the "Senior Citizens and Disabled Persons Property Tax
24 Relief ~~and Pharmaceutical Assistance~~ Act" or any distributions
25 or items of income described under subparagraph (X) of
26 paragraph (2) of subsection (a) of Section 203 of the Illinois

1 Income Tax Act.

2 The Illinois Department may, by rule, set forth criteria
3 under which an assistance unit is ineligible for cash
4 assistance under this Article for a specified number of months
5 due to the receipt of a lump sum payment.

6 (Source: P.A. 96-866, eff. 7-1-10.)

7 (305 ILCS 5/4-2) (from Ch. 23, par. 4-2)

8 Sec. 4-2. Amount of aid.

9 (a) The amount and nature of financial aid shall be
10 determined in accordance with the grant amounts, rules and
11 regulations of the Illinois Department. Due regard shall be
12 given to the self-sufficiency requirements of the family and to
13 the income, money contributions and other support and resources
14 available, from whatever source. However, the amount and nature
15 of any financial aid is not affected by the payment of any
16 grant under the "Senior Citizens and Disabled Persons Property
17 Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any
18 distributions or items of income described under subparagraph
19 (X) of paragraph (2) of subsection (a) of Section 203 of the
20 Illinois Income Tax Act. The aid shall be sufficient, when
21 added to all other income, money contributions and support to
22 provide the family with a grant in the amount established by
23 Department regulation.

24 Subject to appropriation, beginning on July 1, 2008, the
25 Department of Human Services shall increase TANF grant amounts

1 in effect on June 30, 2008 by 15%. The Department is authorized
2 to administer this increase but may not otherwise adopt any
3 rule to implement this increase.

4 (b) The Illinois Department may conduct special projects,
5 which may be known as Grant Diversion Projects, under which
6 recipients of financial aid under this Article are placed in
7 jobs and their grants are diverted to the employer who in turn
8 makes payments to the recipients in the form of salary or other
9 employment benefits. The Illinois Department shall by rule
10 specify the terms and conditions of such Grant Diversion
11 Projects. Such projects shall take into consideration and be
12 coordinated with the programs administered under the Illinois
13 Emergency Employment Development Act.

14 (c) The amount and nature of the financial aid for a child
15 requiring care outside his own home shall be determined in
16 accordance with the rules and regulations of the Illinois
17 Department, with due regard to the needs and requirements of
18 the child in the foster home or institution in which he has
19 been placed.

20 (d) If the Department establishes grants for family units
21 consisting exclusively of a pregnant woman with no dependent
22 child or including her husband if living with her, the grant
23 amount for such a unit shall be equal to the grant amount for
24 an assistance unit consisting of one adult, or 2 persons if the
25 husband is included. Other than as herein described, an unborn
26 child shall not be counted in determining the size of an

1 assistance unit or for calculating grants.

2 Payments for basic maintenance requirements of a child or
3 children and the relative with whom the child or children are
4 living shall be prescribed, by rule, by the Illinois
5 Department.

6 Grants under this Article shall not be supplemented by
7 General Assistance provided under Article VI.

8 (e) Grants shall be paid to the parent or other person with
9 whom the child or children are living, except for such amount
10 as is paid in behalf of the child or his parent or other
11 relative to other persons or agencies pursuant to this Code or
12 the rules and regulations of the Illinois Department.

13 (f) Subject to subsection (f-5), an assistance unit,
14 receiving financial aid under this Article or temporarily
15 ineligible to receive aid under this Article under a penalty
16 imposed by the Illinois Department for failure to comply with
17 the eligibility requirements or that voluntarily requests
18 termination of financial assistance under this Article and
19 becomes subsequently eligible for assistance within 9 months,
20 shall not receive any increase in the amount of aid solely on
21 account of the birth of a child; except that an increase is not
22 prohibited when the birth is (i) of a child of a pregnant woman
23 who became eligible for aid under this Article during the
24 pregnancy, or (ii) of a child born within 10 months after the
25 date of implementation of this subsection, or (iii) of a child
26 conceived after a family became ineligible for assistance due

1 to income or marriage and at least 3 months of ineligibility
2 expired before any reapplication for assistance. This
3 subsection does not, however, prevent a unit from receiving a
4 general increase in the amount of aid that is provided to all
5 recipients of aid under this Article.

6 The Illinois Department is authorized to transfer funds,
7 and shall use any budgetary savings attributable to not
8 increasing the grants due to the births of additional children,
9 to supplement existing funding for employment and training
10 services for recipients of aid under this Article IV. The
11 Illinois Department shall target, to the extent the
12 supplemental funding allows, employment and training services
13 to the families who do not receive a grant increase after the
14 birth of a child. In addition, the Illinois Department shall
15 provide, to the extent the supplemental funding allows, such
16 families with up to 24 months of transitional child care
17 pursuant to Illinois Department rules. All remaining
18 supplemental funds shall be used for employment and training
19 services or transitional child care support.

20 In making the transfers authorized by this subsection, the
21 Illinois Department shall first determine, pursuant to
22 regulations adopted by the Illinois Department for this
23 purpose, the amount of savings attributable to not increasing
24 the grants due to the births of additional children. Transfers
25 may be made from General Revenue Fund appropriations for
26 distributive purposes authorized by Article IV of this Code

1 only to General Revenue Fund appropriations for employability
2 development services including operating and administrative
3 costs and related distributive purposes under Article IXA of
4 this Code. The Director, with the approval of the Governor,
5 shall certify the amount and affected line item appropriations
6 to the State Comptroller.

7 Nothing in this subsection shall be construed to prohibit
8 the Illinois Department from using funds under this Article IV
9 to provide assistance in the form of vouchers that may be used
10 to pay for goods and services deemed by the Illinois
11 Department, by rule, as suitable for the care of the child such
12 as diapers, clothing, school supplies, and cribs.

13 (f-5) Subsection (f) shall not apply to affect the monthly
14 assistance amount of any family as a result of the birth of a
15 child on or after January 1, 2004. As resources permit after
16 January 1, 2004, the Department may cease applying subsection
17 (f) to limit assistance to families receiving assistance under
18 this Article on January 1, 2004, with respect to children born
19 prior to that date. In any event, subsection (f) shall be
20 completely inoperative on and after July 1, 2007.

21 (g) (Blank).

22 (h) Notwithstanding any other provision of this Code, the
23 Illinois Department is authorized to reduce payment levels used
24 to determine cash grants under this Article after December 31
25 of any fiscal year if the Illinois Department determines that
26 the caseload upon which the appropriations for the current

1 fiscal year are based have increased by more than 5% and the
2 appropriation is not sufficient to ensure that cash benefits
3 under this Article do not exceed the amounts appropriated for
4 those cash benefits. Reductions in payment levels may be
5 accomplished by emergency rule under Section 5-45 of the
6 Illinois Administrative Procedure Act, except that the
7 limitation on the number of emergency rules that may be adopted
8 in a 24-month period shall not apply and the provisions of
9 Sections 5-115 and 5-125 of the Illinois Administrative
10 Procedure Act shall not apply. Increases in payment levels
11 shall be accomplished only in accordance with Section 5-40 of
12 the Illinois Administrative Procedure Act. Before any rule to
13 increase payment levels promulgated under this Section shall
14 become effective, a joint resolution approving the rule must be
15 adopted by a roll call vote by a majority of the members
16 elected to each chamber of the General Assembly.

17 (Source: P.A. 95-744, eff. 7-18-08; 95-1055, eff. 4-10-09;
18 96-1000, eff. 7-2-10.)

19 (305 ILCS 5/6-1.2) (from Ch. 23, par. 6-1.2)

20 Sec. 6-1.2. Need. Income available to the person, when
21 added to contributions in money, substance, or services from
22 other sources, including contributions from legally
23 responsible relatives, must be insufficient to equal the grant
24 amount established by Department regulation (or by local
25 governmental unit in units which do not receive State funds)

1 for such a person.

2 In determining income to be taken into account:

3 (1) The first \$75 of earned income in income assistance
4 units comprised exclusively of one adult person shall be
5 disregarded, and for not more than 3 months in any 12
6 consecutive months that portion of earned income beyond the
7 first \$75 that is the difference between the standard of
8 assistance and the grant amount, shall be disregarded.

9 (2) For income assistance units not comprised
10 exclusively of one adult person, when authorized by rules
11 and regulations of the Illinois Department, a portion of
12 earned income, not to exceed the first \$25 a month plus 50%
13 of the next \$75, may be disregarded for the purpose of
14 stimulating and aiding rehabilitative effort and
15 self-support activity.

16 "Earned income" means money earned in self-employment or
17 wages, salary, or commission for personal services performed as
18 an employee. The eligibility of any applicant for or recipient
19 of public aid under this Article is not affected by the payment
20 of any grant under the "Senior Citizens and Disabled Persons
21 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act", any
22 refund or payment of the federal Earned Income Tax Credit, or
23 any distributions or items of income described under
24 subparagraph (X) of paragraph (2) of subsection (a) of Section
25 203 of the Illinois Income Tax Act.

26 (Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

1 (305 ILCS 5/6-2) (from Ch. 23, par. 6-2)

2 Sec. 6-2. Amount of aid. The amount and nature of General
3 Assistance for basic maintenance requirements shall be
4 determined in accordance with local budget standards for local
5 governmental units which do not receive State funds. For local
6 governmental units which do receive State funds, the amount and
7 nature of General Assistance for basic maintenance
8 requirements shall be determined in accordance with the
9 standards, rules and regulations of the Illinois Department.
10 However, the amount and nature of any financial aid is not
11 affected by the payment of any grant under the Senior Citizens
12 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
13 ~~Assistance~~ Act or any distributions or items of income
14 described under subparagraph (X) of paragraph (2) of subsection
15 (a) of Section 203 of the Illinois Income Tax Act. Due regard
16 shall be given to the requirements and the conditions existing
17 in each case, and to the income, money contributions and other
18 support and resources available, from whatever source. In local
19 governmental units which do not receive State funds, the grant
20 shall be sufficient when added to all other income, money
21 contributions and support in excess of any excluded income or
22 resources, to provide the person with a grant in the amount
23 established for such a person by the local governmental unit
24 based upon standards meeting basic maintenance requirements.
25 In local governmental units which do receive State funds, the

1 grant shall be sufficient when added to all other income, money
2 contributions and support in excess of any excluded income or
3 resources, to provide the person with a grant in the amount
4 established for such a person by Department regulation based
5 upon standards providing a livelihood compatible with health
6 and well-being, as directed by Section 12-4.11 of this Code.

7 The Illinois Department may conduct special projects,
8 which may be known as Grant Diversion Projects, under which
9 recipients of financial aid under this Article are placed in
10 jobs and their grants are diverted to the employer who in turn
11 makes payments to the recipients in the form of salary or other
12 employment benefits. The Illinois Department shall by rule
13 specify the terms and conditions of such Grant Diversion
14 Projects. Such projects shall take into consideration and be
15 coordinated with the programs administered under the Illinois
16 Emergency Employment Development Act.

17 The allowances provided under Article IX for recipients
18 participating in the training and rehabilitation programs
19 shall be in addition to such maximum payment.

20 Payments may also be made to provide persons receiving
21 basic maintenance support with necessary treatment, care and
22 supplies required because of illness or disability or with
23 acute medical treatment, care, and supplies. Payments for
24 necessary or acute medical care under this paragraph may be
25 made to or in behalf of the person. Obligations incurred for
26 such services but not paid for at the time of a recipient's

1 death may be paid, subject to the rules and regulations of the
2 Illinois Department, after the death of the recipient.

3 (Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

4 (305 ILCS 5/12-9) (from Ch. 23, par. 12-9)

5 Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The
6 Public Aid Recoveries Trust Fund shall consist of (1)
7 recoveries by the Department of Healthcare and Family Services
8 (formerly Illinois Department of Public Aid) authorized by this
9 Code in respect to applicants or recipients under Articles III,
10 IV, V, and VI, including recoveries made by the Department of
11 Healthcare and Family Services (formerly Illinois Department
12 of Public Aid) from the estates of deceased recipients, (2)
13 recoveries made by the Department of Healthcare and Family
14 Services (formerly Illinois Department of Public Aid) in
15 respect to applicants and recipients under the Children's
16 Health Insurance Program Act, and the Covering ALL KIDS Health
17 Insurance Act, ~~and the Senior Citizens and Disabled Persons
18 Property Tax Relief and Pharmaceutical Assistance Act,~~ (3)
19 federal funds received on behalf of and earned by State
20 universities and local governmental entities for services
21 provided to applicants or recipients covered under this Code,
22 the Children's Health Insurance Program Act, and the Covering
23 ALL KIDS Health Insurance Act, ~~and the Senior Citizens and
24 Disabled Persons Property Tax Relief and Pharmaceutical
25 Assistance Act,~~ (3.5) federal financial participation revenue

1 related to eligible disbursements made by the Department of
2 Healthcare and Family Services from appropriations required by
3 this Section, and (4) all other moneys received to the Fund,
4 including interest thereon. The Fund shall be held as a special
5 fund in the State Treasury.

6 Disbursements from this Fund shall be only (1) for the
7 reimbursement of claims collected by the Department of
8 Healthcare and Family Services (formerly Illinois Department
9 of Public Aid) through error or mistake, (2) for payment to
10 persons or agencies designated as payees or co-payees on any
11 instrument, whether or not negotiable, delivered to the
12 Department of Healthcare and Family Services (formerly
13 Illinois Department of Public Aid) as a recovery under this
14 Section, such payment to be in proportion to the respective
15 interests of the payees in the amount so collected, (3) for
16 payments to the Department of Human Services for collections
17 made by the Department of Healthcare and Family Services
18 (formerly Illinois Department of Public Aid) on behalf of the
19 Department of Human Services under this Code, the Children's
20 Health Insurance Program Act, and the Covering ALL KIDS Health
21 Insurance Act, (4) for payment of administrative expenses
22 incurred in performing the activities authorized under this
23 Code, the Children's Health Insurance Program Act, and the
24 Covering ALL KIDS Health Insurance Act, ~~and the Senior Citizens~~
25 ~~and Disabled Persons Property Tax Relief and Pharmaceutical~~
26 ~~Assistance Act,~~ (5) for payment of fees to persons or agencies

1 in the performance of activities pursuant to the collection of
2 monies owed the State that are collected under this Code, the
3 Children's Health Insurance Program Act, and the Covering ALL
4 KIDS Health Insurance Act, ~~and the Senior Citizens and Disabled
5 Persons Property Tax Relief and Pharmaceutical Assistance Act,~~
6 (6) for payments of any amounts which are reimbursable to the
7 federal government which are required to be paid by State
8 warrant by either the State or federal government, and (7) for
9 payments to State universities and local governmental entities
10 of federal funds for services provided to applicants or
11 recipients covered under this Code, the Children's Health
12 Insurance Program Act, and the Covering ALL KIDS Health
13 Insurance Act, ~~and the Senior Citizens and Disabled Persons
14 Property Tax Relief and Pharmaceutical Assistance Act.~~
15 Disbursements from this Fund for purposes of items (4) and (5)
16 of this paragraph shall be subject to appropriations from the
17 Fund to the Department of Healthcare and Family Services
18 (formerly Illinois Department of Public Aid).

19 The balance in this Fund on the first day of each calendar
20 quarter, after payment therefrom of any amounts reimbursable to
21 the federal government, and minus the amount reasonably
22 anticipated to be needed to make the disbursements during that
23 quarter authorized by this Section, shall be certified by the
24 Director of Healthcare and Family Services and transferred by
25 the State Comptroller to the Drug Rebate Fund or the Healthcare
26 Provider Relief Fund in the State Treasury, as appropriate,

1 within 30 days of the first day of each calendar quarter. The
2 Director of Healthcare and Family Services may certify and the
3 State Comptroller shall transfer to the Drug Rebate Fund
4 amounts on a more frequent basis.

5 On July 1, 1999, the State Comptroller shall transfer the
6 sum of \$5,000,000 from the Public Aid Recoveries Trust Fund
7 (formerly the Public Assistance Recoveries Trust Fund) into the
8 DHS Recoveries Trust Fund.

9 (Source: P.A. 96-1100, eff. 1-1-11; 97-647, eff. 1-1-12.)

10 Section 960. The Senior Citizens Real Estate Tax Deferral
11 Act is amended by changing Sections 2 and 8 as follows:

12 (320 ILCS 30/2) (from Ch. 67 1/2, par. 452)

13 Sec. 2. Definitions. As used in this Act:

14 (a) "Taxpayer" means an individual whose household income
15 for the year is no greater than: (i) \$40,000 through tax year
16 2005; (ii) \$50,000 for tax years 2006 through 2011; and (iii)
17 \$55,000 for tax year 2012 and thereafter.

18 (b) "Tax deferred property" means the property upon which
19 real estate taxes are deferred under this Act.

20 (c) "Homestead" means the land and buildings thereon,
21 including a condominium or a dwelling unit in a multidwelling
22 building that is owned and operated as a cooperative, occupied
23 by the taxpayer as his residence or which are temporarily
24 unoccupied by the taxpayer because such taxpayer is temporarily

1 residing, for not more than 1 year, in a licensed facility as
2 defined in Section 1-113 of the Nursing Home Care Act.

3 (d) "Real estate taxes" or "taxes" means the taxes on real
4 property for which the taxpayer would be liable under the
5 Property Tax Code, including special service area taxes, and
6 special assessments on benefited real property for which the
7 taxpayer would be liable to a unit of local government.

8 (e) "Department" means the Department of Revenue.

9 (f) "Qualifying property" means a homestead which (a) the
10 taxpayer or the taxpayer and his spouse own in fee simple or
11 are purchasing in fee simple under a recorded instrument of
12 sale, (b) is not income-producing property, (c) is not subject
13 to a lien for unpaid real estate taxes when a claim under this
14 Act is filed, and (d) is not held in trust, other than an
15 Illinois land trust with the taxpayer identified as the sole
16 beneficiary, if the taxpayer is filing for the program for the
17 first time effective as of the January 1, 2011 assessment year
18 or tax year 2012 and thereafter.

19 (g) "Equity interest" means the current assessed valuation
20 of the qualified property times the fraction necessary to
21 convert that figure to full market value minus any outstanding
22 debts or liens on that property. In the case of qualifying
23 property not having a separate assessed valuation, the
24 appraised value as determined by a qualified real estate
25 appraiser shall be used instead of the current assessed
26 valuation.

1 (h) "Household income" has the meaning ascribed to that
2 term in the Senior Citizens and Disabled Persons Property Tax
3 Relief ~~and Pharmaceutical Assistance~~ Act.

4 (i) "Collector" means the county collector or, if the taxes
5 to be deferred are special assessments, an official designated
6 by a unit of local government to collect special assessments.
7 (Source: P.A. 97-481, eff. 8-22-11.)

8 (320 ILCS 30/8) (from Ch. 67 1/2, par. 458)

9 Sec. 8. Nothing in this Act (a) affects any provision of
10 any mortgage or other instrument relating to land requiring a
11 person to pay real estate taxes or (b) affects the eligibility
12 of any person to receive any grant pursuant to the "Senior
13 Citizens and Disabled Persons Property Tax Relief ~~and~~
14 ~~Pharmaceutical Assistance~~ Act".

15 (Source: P.A. 84-807; 84-832.)

16 Section 965. The Senior Pharmaceutical Assistance Act is
17 amended by changing Section 5 as follows:

18 (320 ILCS 50/5)

19 Sec. 5. Findings. The General Assembly finds:

20 (1) Senior citizens identify pharmaceutical assistance as
21 the single most critical factor to their health, well-being,
22 and continued independence.

23 (2) The State of Illinois currently operates 2

1 pharmaceutical assistance programs that benefit seniors: (i)
2 the program of pharmaceutical assistance under the Senior
3 Citizens and Disabled Persons Property Tax Relief ~~and~~
4 ~~Pharmaceutical Assistance~~ Act and (ii) the Aid to the Aged,
5 Blind, or Disabled program under the Illinois Public Aid Code.
6 The State has been given authority to establish a third
7 program, SeniorRx Care, through a federal Medicaid waiver.

8 (3) Each year, numerous pieces of legislation are filed
9 seeking to establish additional pharmaceutical assistance
10 benefits for seniors or to make changes to the existing
11 programs.

12 (4) Establishment of a pharmaceutical assistance review
13 committee will ensure proper coordination of benefits,
14 diminish the likelihood of duplicative benefits, and ensure
15 that the best interests of seniors are served.

16 (5) In addition to the State pharmaceutical assistance
17 programs, several private entities, such as drug manufacturers
18 and pharmacies, also offer prescription drug discount or
19 coverage programs.

20 (6) Many seniors are unaware of the myriad of public and
21 private programs available to them.

22 (7) Establishing a pharmaceutical clearinghouse with a
23 toll-free hot-line and local outreach workers will educate
24 seniors about the vast array of options available to them and
25 enable seniors to make an educated and informed choice that is
26 best for them.

1 (8) Estimates indicate that almost one-third of senior
2 citizens lack prescription drug coverage. The federal
3 government, states, and the pharmaceutical industry each have a
4 role in helping these uninsured seniors gain access to
5 life-saving medications.

6 (9) The State of Illinois has recognized its obligation to
7 assist Illinois' neediest seniors in purchasing prescription
8 medications, and it is now time for pharmaceutical
9 manufacturers to recognize their obligation to make their
10 medications affordable to seniors.

11 (Source: P.A. 92-594, eff. 6-27-02.)

12 Section 970. The Illinois Vehicle Code is amended by
13 changing Sections 3-609, 3-623, 3-626, 3-667, 3-683, 3-806.3,
14 and 11-1301.2 as follows:

15 (625 ILCS 5/3-609) (from Ch. 95 1/2, par. 3-609)

16 Sec. 3-609. Disabled Veterans' Plates. Any veteran may make
17 application for the registration of one motor vehicle of the
18 first division or one motor vehicle of the second division
19 weighing not more than 8,000 pounds to the Secretary of State
20 without the payment of any registration fee if (i) the veteran
21 holds proof of a service-connected disability from the United
22 States Department of Veterans Affairs and (ii) a licensed
23 physician, physician assistant, or advanced practice nurse has
24 certified in accordance with Section 3-616 that because of the

1 service-connected disability the veteran qualifies for
2 issuance of registration plates or decals to a person with
3 disabilities. The Secretary may, in his or her discretion,
4 allow the plates to be issued as vanity or personalized plates
5 in accordance with Section 3-405.1 of this Code. Registration
6 shall be for a multi-year period and may be issued staggered
7 registration.

8 Renewal of such registration must be accompanied with
9 documentation for eligibility of registration without fee
10 unless the applicant has a permanent qualifying disability, and
11 such registration plates may not be issued to any person not
12 eligible therefor.

13 The Illinois Department of Veterans' Affairs may assist in
14 providing the documentation of disability.

15 Commencing with the 2009 registration year, any person
16 eligible to receive license plates under this Section who has
17 been approved for benefits under the Senior Citizens and
18 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
19 ~~Assistance~~ Act, or who has claimed and received a grant under
20 that Act, shall pay a fee of \$24 instead of the fee otherwise
21 provided in this Code for passenger cars displaying standard
22 multi-year registration plates issued under Section 3-414.1,
23 for motor vehicles registered at 8,000 pounds or less under
24 Section 3-815(a), or for recreational vehicles registered at
25 8,000 pounds or less under Section 3-815(b), for a second set
26 of plates under this Section.

1 (Source: P.A. 95-157, eff. 1-1-08; 95-167, eff. 1-1-08; 95-353,
2 eff. 1-1-08; 95-876, eff. 8-21-08; 96-79, eff. 1-1-10.)

3 (625 ILCS 5/3-623) (from Ch. 95 1/2, par. 3-623)

4 Sec. 3-623. Purple Heart Plates. The Secretary, upon
5 receipt of an application made in the form prescribed by the
6 Secretary of State, may issue to recipients awarded the Purple
7 Heart by a branch of the armed forces of the United States who
8 reside in Illinois, special registration plates. The
9 Secretary, upon receipt of the proper application, may also
10 issue these special registration plates to an Illinois resident
11 who is the surviving spouse of a person who was awarded the
12 Purple Heart by a branch of the armed forces of the United
13 States. The special plates issued pursuant to this Section
14 should be affixed only to passenger vehicles of the 1st
15 division, including motorcycles, or motor vehicles of the 2nd
16 division weighing not more than 8,000 pounds. The Secretary
17 may, in his or her discretion, allow the plates to be issued as
18 vanity or personalized plates in accordance with Section
19 3-405.1 of this Code. The Secretary of State must make a
20 version of the special registration plates authorized under
21 this Section in a form appropriate for motorcycles.

22 The design and color of such plates shall be wholly within
23 the discretion of the Secretary of State. Appropriate
24 documentation, as determined by the Secretary, and the
25 appropriate registration fee shall accompany the application.

1 However, for an individual who has been issued Purple Heart
2 plates for a vehicle and who has been approved for benefits
3 under the Senior Citizens and Disabled Persons Property Tax
4 Relief ~~and Pharmaceutical Assistance~~ Act, the annual fee for
5 the registration of the vehicle shall be as provided in Section
6 3-806.3 of this Code.

7 (Source: P.A. 95-331, eff. 8-21-07; 95-353, eff. 1-1-08;
8 96-1101, eff. 1-1-11.)

9 (625 ILCS 5/3-626)

10 Sec. 3-626. Korean War Veteran license plates.

11 (a) In addition to any other special license plate, the
12 Secretary, upon receipt of all applicable fees and applications
13 made in the form prescribed by the Secretary of State, may
14 issue special registration plates designated as Korean War
15 Veteran license plates to residents of Illinois who
16 participated in the United States Armed Forces during the
17 Korean War. The special plate issued under this Section shall
18 be affixed only to passenger vehicles of the first division,
19 motorcycles, motor vehicles of the second division weighing not
20 more than 8,000 pounds, and recreational vehicles as defined by
21 Section 1-169 of this Code. Plates issued under this Section
22 shall expire according to the staggered multi-year procedure
23 established by Section 3-414.1 of this Code.

24 (b) The design, color, and format of the plates shall be
25 wholly within the discretion of the Secretary of State. The

1 Secretary may, in his or her discretion, allow the plates to be
2 issued as vanity plates or personalized in accordance with
3 Section 3-405.1 of this Code. The plates are not required to
4 designate "Land Of Lincoln", as prescribed in subsection (b) of
5 Section 3-412 of this Code. The Secretary shall prescribe the
6 eligibility requirements and, in his or her discretion, shall
7 approve and prescribe stickers or decals as provided under
8 Section 3-412.

9 (c) (Blank).

10 (d) The Korean War Memorial Construction Fund is created as
11 a special fund in the State treasury. All moneys in the Korean
12 War Memorial Construction Fund shall, subject to
13 appropriation, be used by the Department of Veteran Affairs to
14 provide grants for construction of the Korean War Memorial to
15 be located at Oak Ridge Cemetery in Springfield, Illinois. Upon
16 the completion of the Memorial, the Department of Veteran
17 Affairs shall certify to the State Treasurer that the
18 construction of the Memorial has been completed. Upon the
19 certification by the Department of Veteran Affairs, the State
20 Treasurer shall transfer all moneys in the Fund and any future
21 deposits into the Fund into the Secretary of State Special
22 License Plate Fund.

23 (e) An individual who has been issued Korean War Veteran
24 license plates for a vehicle and who has been approved for
25 benefits under the Senior Citizens and Disabled Persons
26 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay

1 the original issuance and the regular annual fee for the
2 registration of the vehicle as provided in Section 3-806.3 of
3 this Code in addition to the fees specified in subsection (c)
4 of this Section.

5 (Source: P.A. 96-1409, eff. 1-1-11.)

6 (625 ILCS 5/3-667)

7 Sec. 3-667. Korean Service license plates.

8 (a) In addition to any other special license plate, the
9 Secretary, upon receipt of all applicable fees and applications
10 made in the form prescribed by the Secretary of State, may
11 issue special registration plates designated as Korean Service
12 license plates to residents of Illinois who, on or after July
13 27, 1954, participated in the United States Armed Forces in
14 Korea. The special plate issued under this Section shall be
15 affixed only to passenger vehicles of the first division,
16 motorcycles, motor vehicles of the second division weighing not
17 more than 8,000 pounds, and recreational vehicles as defined by
18 Section 1-169 of this Code. Plates issued under this Section
19 shall expire according to the staggered multi-year procedure
20 established by Section 3-414.1 of this Code.

21 (b) The design, color, and format of the plates shall be
22 wholly within the discretion of the Secretary of State. The
23 Secretary may, in his or her discretion, allow the plates to be
24 issued as vanity or personalized plates in accordance with
25 Section 3-405.1 of this Code. The plates are not required to

1 designate "Land of Lincoln", as prescribed in subsection (b) of
2 Section 3-412 of this Code. The Secretary shall prescribe the
3 eligibility requirements and, in his or her discretion, shall
4 approve and prescribe stickers or decals as provided under
5 Section 3-412.

6 (c) An applicant shall be charged a \$2 fee for original
7 issuance in addition to the applicable registration fee. This
8 additional fee shall be deposited into the Korean War Memorial
9 Construction Fund a special fund in the State treasury.

10 (d) An individual who has been issued Korean Service
11 license plates for a vehicle and who has been approved for
12 benefits under the Senior Citizens and Disabled Persons
13 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay
14 the original issuance and the regular annual fee for the
15 registration of the vehicle as provided in Section 3-806.3 of
16 this Code in addition to the fees specified in subsection (c)
17 of this Section.

18 (Source: P.A. 97-306, eff. 1-1-12.)

19 (625 ILCS 5/3-683)

20 Sec. 3-683. Distinguished Service Cross license plates.
21 The Secretary, upon receipt of an application made in the form
22 prescribed by the Secretary of State, shall issue special
23 registration plates to any Illinois resident who has been
24 awarded the Distinguished Service Cross by a branch of the
25 armed forces of the United States. The Secretary, upon receipt

1 of the proper application, shall also issue these special
2 registration plates to an Illinois resident who is the
3 surviving spouse of a person who was awarded the Distinguished
4 Service Cross by a branch of the armed forces of the United
5 States. The special plates issued under this Section should be
6 affixed only to passenger vehicles of the first division,
7 including motorcycles, or motor vehicles of the second division
8 weighing not more than 8,000 pounds.

9 The design and color of the 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 Distinguished
14 Service Cross plates for a vehicle and who has been approved
15 for benefits under the Senior Citizens and Disabled Persons
16 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, the
17 annual fee for the registration of the vehicle shall be as
18 provided in Section 3-806.3 of this Code.

19 (Source: P.A. 95-794, eff. 1-1-09; 96-328, eff. 8-11-09.)

20 (625 ILCS 5/3-806.3) (from Ch. 95 1/2, par. 3-806.3)

21 Sec. 3-806.3. Senior Citizens. Commencing with the 2009
22 registration year, the registration fee paid by any vehicle
23 owner who has been approved for benefits under the Senior
24 Citizens and Disabled Persons Property Tax Relief ~~and~~
25 ~~Pharmaceutical Assistance~~ Act or who is the spouse of such a

1 person shall be \$24 instead of the fee otherwise provided in
2 this Code for passenger cars displaying standard multi-year
3 registration plates issued under Section 3-414.1, motor
4 vehicles displaying special registration plates issued under
5 Section 3-609, 3-616, 3-621, 3-622, 3-623, 3-624, 3-625, 3-626,
6 3-628, 3-638, 3-642, 3-645, 3-647, 3-650, 3-651, or 3-663,
7 motor vehicles registered at 8,000 pounds or less under Section
8 3-815(a), and recreational vehicles registered at 8,000 pounds
9 or less under Section 3-815(b). Widows and widowers of
10 claimants shall also be entitled to this reduced registration
11 fee for the registration year in which the claimant was
12 eligible.

13 Commencing with the 2009 registration year, the
14 registration fee paid by any vehicle owner who has claimed and
15 received a grant under the Senior Citizens and Disabled Persons
16 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or who is
17 the spouse of such a person shall be \$24 instead of the fee
18 otherwise provided in this Code for passenger cars displaying
19 standard multi-year registration plates issued under Section
20 3-414.1, motor vehicles displaying special registration plates
21 issued under Section 3-607, 3-609, 3-616, 3-621, 3-622, 3-623,
22 3-624, 3-625, 3-626, 3-628, 3-638, 3-642, 3-645, 3-647, 3-650,
23 3-651, 3-663, or 3-664, motor vehicles registered at 8,000
24 pounds or less under Section 3-815(a), and recreational
25 vehicles registered at 8,000 pounds or less under Section
26 3-815(b). Widows and widowers of claimants shall also be

1 entitled to this reduced registration fee for the registration
2 year in which the claimant was eligible.

3 No more than one reduced registration fee under this
4 Section shall be allowed during any 12 month period based on
5 the primary eligibility of any individual, whether such reduced
6 registration fee is allowed to the individual or to the spouse,
7 widow or widower of such individual. This Section does not
8 apply to the fee paid in addition to the registration fee for
9 motor vehicles displaying vanity or special license plates.

10 (Source: P.A. 95-157, eff. 1-1-08; 95-331, eff. 8-21-07;
11 95-876, eff. 8-21-08; 96-554, eff. 1-1-10.)

12 (625 ILCS 5/11-1301.2) (from Ch. 95 1/2, par. 11-1301.2)

13 Sec. 11-1301.2. Special decals for parking; persons with
14 disabilities.

15 (a) The Secretary of State shall provide for, by
16 administrative rules, the design, size, color, and placement of
17 a person with disabilities motorist decal or device and shall
18 provide for, by administrative rules, the content and form of
19 an application for a person with disabilities motorist decal or
20 device, which shall be used by local authorities in the
21 issuance thereof to a person with temporary disabilities,
22 provided that the decal or device is valid for no more than 90
23 days, subject to renewal for like periods based upon continued
24 disability, and further provided that the decal or device
25 clearly sets forth the date that the decal or device expires.

1 The application shall include the requirement of an Illinois
2 Identification Card number or a State of Illinois driver's
3 license number. This decal or device may be used by the
4 authorized holder to designate and identify a vehicle not owned
5 or displaying a registration plate as provided in Sections
6 3-609 and 3-616 of this Act to designate when the vehicle is
7 being used to transport said person or persons with
8 disabilities, and thus is entitled to enjoy all the privileges
9 that would be afforded a person with disabilities licensed
10 vehicle. Person with disabilities decals or devices issued and
11 displayed pursuant to this Section shall be recognized and
12 honored by all local authorities regardless of which local
13 authority issued such decal or device.

14 The decal or device shall be issued only upon a showing by
15 adequate documentation that the person for whose benefit the
16 decal or device is to be used has a temporary disability as
17 defined in Section 1-159.1 of this Code.

18 (b) The local governing authorities shall be responsible
19 for the provision of such decal or device, its issuance and
20 designated placement within the vehicle. The cost of such decal
21 or device shall be at the discretion of such local governing
22 authority.

23 (c) The Secretary of State may, pursuant to Section
24 3-616(c), issue a person with disabilities parking decal or
25 device to a person with disabilities as defined by Section
26 1-159.1. Any person with disabilities parking decal or device

1 issued by the Secretary of State shall be registered to that
2 person with disabilities in the form to be prescribed by the
3 Secretary of State. The person with disabilities parking decal
4 or device shall not display that person's address. One
5 additional decal or device may be issued to an applicant upon
6 his or her written request and with the approval of the
7 Secretary of State. The written request must include a
8 justification of the need for the additional decal or device.

9 (d) Replacement decals or devices may be issued for lost,
10 stolen, or destroyed decals upon application and payment of a
11 \$10 fee. The replacement fee may be waived for individuals that
12 have claimed and received a grant under the Senior Citizens and
13 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
14 ~~Assistance~~ Act.

15 (Source: P.A. 95-167, eff. 1-1-08; 96-72, eff. 1-1-10; 96-79,
16 eff. 1-1-10; 96-1000, eff. 7-2-10.)

17 Section 975. The Criminal Code of 1961 is amended by
18 changing Section 17-6.5 as follows:

19 (720 ILCS 5/17-6.5)

20 Sec. 17-6.5. Persons under deportation order;
21 ineligibility for benefits.

22 (a) An individual against whom a United States Immigration
23 Judge has issued an order of deportation which has been
24 affirmed by the Board of Immigration Review, as well as an

1 individual who appeals such an order pending appeal, under
2 paragraph 19 of Section 241(a) of the Immigration and
3 Nationality Act relating to persecution of others on account of
4 race, religion, national origin or political opinion under the
5 direction of or in association with the Nazi government of
6 Germany or its allies, shall be ineligible for the following
7 benefits authorized by State law:

8 (1) The homestead exemptions and homestead improvement
9 exemption under Sections 15-170, 15-175, 15-176, and
10 15-180 of the Property Tax Code.

11 (2) Grants under the Senior Citizens and Disabled
12 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~
13 Act.

14 (3) The double income tax exemption conferred upon
15 persons 65 years of age or older by Section 204 of the
16 Illinois Income Tax Act.

17 (4) Grants provided by the Department on Aging.

18 (5) Reductions in vehicle registration fees under
19 Section 3-806.3 of the Illinois Vehicle Code.

20 (6) Free fishing and reduced fishing license fees under
21 Sections 20-5 and 20-40 of the Fish and Aquatic Life Code.

22 (7) Tuition free courses for senior citizens under the
23 Senior Citizen Courses Act.

24 (8) Any benefits under the Illinois Public Aid Code.

25 (b) If a person has been found by a court to have knowingly
26 received benefits in violation of subsection (a) and:

1 (1) the total monetary value of the benefits received
2 is less than \$150, the person is guilty of a Class A
3 misdemeanor; a second or subsequent violation is a Class 4
4 felony;

5 (2) the total monetary value of the benefits received
6 is \$150 or more but less than \$1,000, the person is guilty
7 of a Class 4 felony; a second or subsequent violation is a
8 Class 3 felony;

9 (3) the total monetary value of the benefits received
10 is \$1,000 or more but less than \$5,000, the person is
11 guilty of a Class 3 felony; a second or subsequent
12 violation is a Class 2 felony;

13 (4) the total monetary value of the benefits received
14 is \$5,000 or more but less than \$10,000, the person is
15 guilty of a Class 2 felony; a second or subsequent
16 violation is a Class 1 felony; or

17 (5) the total monetary value of the benefits received
18 is \$10,000 or more, the person is guilty of a Class 1
19 felony.

20 (c) For purposes of determining the classification of an
21 offense under this Section, all of the monetary value of the
22 benefits received as a result of the unlawful act, practice, or
23 course of conduct may be accumulated.

24 (d) Any grants awarded to persons described in subsection
25 (a) may be recovered by the State of Illinois in a civil action
26 commenced by the Attorney General in the circuit court of

1 Sangamon County or the State's Attorney of the county of
2 residence of the person described in subsection (a).

3 (e) An individual described in subsection (a) who has been
4 deported shall be restored to any benefits which that
5 individual has been denied under State law pursuant to
6 subsection (a) if (i) the Attorney General of the United States
7 has issued an order cancelling deportation and has adjusted the
8 status of the individual to that of an alien lawfully admitted
9 for permanent residence in the United States or (ii) the
10 country to which the individual has been deported adjudicates
11 or exonerates the individual in a judicial or administrative
12 proceeding as not being guilty of the persecution of others on
13 account of race, religion, national origin, or political
14 opinion under the direction of or in association with the Nazi
15 government of Germany or its allies.

16 (Source: P.A. 96-1551, eff. 7-1-11.)

17 Section 995. Severability. If any provision of this Act or
18 application thereof to any person or circumstance is held
19 invalid, such invalidity does not affect other provisions or
20 applications of this Act which can be given effect without the
21 invalid application or provision, and to this end the
22 provisions of this Act are declared to be severable.

23 Section 998. This Act does not take effect at all unless
24 both House Bill 5007, as amended, of the 97th General Assembly

1 and Senate Bill 3397, as amended, of the 97th General Assembly
2 become law.

3 Section 999. Effective date. This Act takes effect upon
4 becoming law, except that Sections 15, 20, 30, and 85 take
5 effect on July 1, 2012.