



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

HB3119

Introduced 2/19/2021, by Rep. Robyn Gabel

#### SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Public Aid Code. Provides that, subject to federal approval, children younger than age 19 shall be eligible for medical assistance when countable income is at or below 313% (rather than 133%) of the federal poverty level as determined by the Department of Healthcare and Family Services and in accordance with applicable federal requirements. Provides that any individual determined eligible for medical assistance as of or during the COVID-19 public health emergency may be treated as eligible for such medical assistance benefits during the COVID-19 public health emergency, and up to 12 months after the period expires, regardless of whether federally required or whether the individual's eligibility may be State or federally funded, unless the individual requests a voluntary termination of eligibility or ceases to be a resident. Provides that the amendatory Act shall not restrict any determination of medical need or appropriateness for any particular service and shall not require continued coverage of any particular service that may be no longer necessary, appropriate, or otherwise authorized for an individual. Provides that nothing shall prevent the Department from determining and properly establishing an individual's eligibility under a different category of eligibility. Repeals the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act. Makes conforming changes to various Acts.

LRB102 14580 KTG 19933 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 5. The State Finance Act is amended by changing  
5 Sections 6z-52, 6z-81, and 25 as follows:

6 (30 ILCS 105/6z-52)

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

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

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

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

20 (1.5) For payments to managed care organizations as  
21 defined in Section 5-30.1 of the Illinois Public Aid Code.

22 (2) For reimbursement of moneys collected by the  
23 Department of Healthcare and Family Services (formerly

1 Illinois Department of Public Aid) through error or  
2 mistake.

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

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

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

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

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

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

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

11 (Source: P.A. 100-23, eff. 7-6-17.)

12           (30 ILCS 105/6z-81)

13           Sec. 6z-81. Healthcare Provider Relief Fund.

14           (a) There is created in the State treasury a special fund  
15 to be known as the Healthcare Provider Relief Fund.

16           (b) The Fund is created for the purpose of receiving and  
17 disbursing moneys in accordance with this Section.  
18 Disbursements from the Fund shall be made only as follows:

19           (1) Subject to appropriation, for payment by the  
20 Department of Healthcare and Family Services or by the  
21 Department of Human Services of medical bills and related  
22 expenses, including administrative expenses, for which the  
23 State is responsible under Titles XIX and XXI of the  
24 Social Security Act, the Illinois Public Aid Code, ~~the~~  
25 ~~Children's Health Insurance Program Act, the Covering ALL~~

1 ~~KIDS Health Insurance Act,~~ and the Long Term Acute Care  
2 Hospital Quality Improvement Transfer Program Act.

3 (2) For repayment of funds borrowed from other State  
4 funds or from outside sources, including interest thereon.

5 (3) For making payments to the human poison control  
6 center pursuant to Section 12-4.105 of the Illinois Public  
7 Aid Code.

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

9 (1) Moneys received by the State from short-term  
10 borrowing pursuant to the Short Term Borrowing Act on or  
11 after the effective date of Public Act 96-820.

12 (2) All federal matching funds received by the  
13 Illinois Department of Healthcare and Family Services as a  
14 result of expenditures made by the Department that are  
15 attributable to moneys deposited in the Fund.

16 (3) All federal matching funds received by the  
17 Illinois Department of Healthcare and Family Services as a  
18 result of federal approval of Title XIX State plan  
19 amendment transmittal number 07-09.

20 (3.5) Proceeds from the assessment authorized under  
21 Article V-H of the Illinois Public Aid Code.

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

24 (5) All federal matching funds received by the  
25 Illinois Department of Healthcare and Family Services as a  
26 result of expenditures made by the Department for Medical

1 Assistance from the General Revenue Fund, the Tobacco  
2 Settlement Recovery Fund, the Long-Term Care Provider  
3 Fund, and the Drug Rebate Fund related to individuals  
4 eligible for medical assistance pursuant to the Patient  
5 Protection and Affordable Care Act (P.L. 111-148) and  
6 Section 5-2 of the Illinois Public Aid Code.

7 (d) In addition to any other transfers that may be  
8 provided for by law, on the effective date of Public Act 97-44,  
9 or as soon thereafter as practical, the State Comptroller  
10 shall direct and the State Treasurer shall transfer the sum of  
11 \$365,000,000 from the General Revenue Fund into the Healthcare  
12 Provider Relief Fund.

13 (e) In addition to any other transfers that may be  
14 provided for by law, on July 1, 2011, or as soon thereafter as  
15 practical, the State Comptroller shall direct and the State  
16 Treasurer shall transfer the sum of \$160,000,000 from the  
17 General Revenue Fund to the Healthcare Provider Relief Fund.

18 (f) Notwithstanding any other State law to the contrary,  
19 and in addition to any other transfers that may be provided for  
20 by law, the State Comptroller shall order transferred and the  
21 State Treasurer shall transfer \$500,000,000 to the Healthcare  
22 Provider Relief Fund from the General Revenue Fund in equal  
23 monthly installments of \$100,000,000, with the first transfer  
24 to be made on July 1, 2012, or as soon thereafter as practical,  
25 and with each of the remaining transfers to be made on August  
26 1, 2012, September 1, 2012, October 1, 2012, and November 1,

1 2012, or as soon thereafter as practical. This transfer may  
2 assist the Department of Healthcare and Family Services in  
3 improving Medical Assistance bill processing timeframes or in  
4 meeting the possible requirements of Senate Bill 3397, or  
5 other similar legislation, of the 97th General Assembly should  
6 it become law.

7 (g) Notwithstanding any other State law to the contrary,  
8 and in addition to any other transfers that may be provided for  
9 by law, on July 1, 2013, or as soon thereafter as may be  
10 practical, the State Comptroller shall direct and the State  
11 Treasurer shall transfer the sum of \$601,000,000 from the  
12 General Revenue Fund to the Healthcare Provider Relief Fund.

13 (Source: P.A. 100-587, eff. 6-4-18; 101-9, eff. 6-5-19;  
14 101-650, eff. 7-7-20.)

15 (30 ILCS 105/25) (from Ch. 127, par. 161)

16 Sec. 25. Fiscal year limitations.

17 (a) All appropriations shall be available for expenditure  
18 for the fiscal year or for a lesser period if the Act making  
19 that appropriation so specifies. A deficiency or emergency  
20 appropriation shall be available for expenditure only through  
21 June 30 of the year when the Act making that appropriation is  
22 enacted unless that Act otherwise provides.

23 (b) Outstanding liabilities as of June 30, payable from  
24 appropriations which have otherwise expired, may be paid out  
25 of the expiring appropriations during the 2-month period

1 ending at the close of business on August 31. Any service  
2 involving professional or artistic skills or any personal  
3 services by an employee whose compensation is subject to  
4 income tax withholding must be performed as of June 30 of the  
5 fiscal year in order to be considered an "outstanding  
6 liability as of June 30" that is thereby eligible for payment  
7 out of the expiring appropriation.

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

23 (b-2) (Blank).

24 (b-2.5) (Blank).

25 (b-2.6) (Blank).

26 (b-2.6a) (Blank).



1 (b-2.6b) (Blank).

2 (b-2.6c) (Blank).

3 (b-2.6d) All outstanding liabilities as of June 30, 2020,  
4 payable from appropriations that would otherwise expire at the  
5 conclusion of the lapse period for fiscal year 2020, and  
6 interest penalties payable on those liabilities under the  
7 State Prompt Payment Act, may be paid out of the expiring  
8 appropriations until December 31, 2020, without regard to the  
9 fiscal year in which the payment is made, as long as vouchers  
10 for the liabilities are received by the Comptroller no later  
11 than September 30, 2020.

12 (b-2.7) For fiscal years 2012, 2013, 2014, 2018, 2019,  
13 2020, and 2021, interest penalties payable under the State  
14 Prompt Payment Act associated with a voucher for which payment  
15 is issued after June 30 may be paid out of the next fiscal  
16 year's appropriation. The future year appropriation must be  
17 for the same purpose and from the same fund as the original  
18 payment. An interest penalty voucher submitted against a  
19 future year appropriation must be submitted within 60 days  
20 after the issuance of the associated voucher, except that, for  
21 fiscal year 2018 only, an interest penalty voucher submitted  
22 against a future year appropriation must be submitted within  
23 60 days of June 5, 2019 (the effective date of Public Act  
24 101-10). The Comptroller must issue the interest payment  
25 within 60 days after acceptance of the interest voucher.

26 (b-3) Medical payments may be made by the Department of

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

10 (b-4) Medical payments and child care payments may be made  
11 by the Department of Human Services (as successor to the  
12 Department of Public Aid) from appropriations for those  
13 purposes for any fiscal year, without regard to the fact that  
14 the medical or child care services being compensated for by  
15 such payment may have been rendered in a prior fiscal year; and  
16 payments may be made at the direction of the Department of  
17 Healthcare and Family Services (or successor agency) from the  
18 Health Insurance Reserve Fund without regard to any fiscal  
19 year limitations, except as required by subsection (j) of this  
20 Section. Beginning on June 30, 2021, medical and child care  
21 payments made by the Department of Human Services and payments  
22 made at the discretion of the Department of Healthcare and  
23 Family Services (or successor agency) from the Health  
24 Insurance Reserve Fund and payable from appropriations that  
25 have otherwise expired may be paid out of the expiring  
26 appropriation during the 4-month period ending at the close of

1 business on October 31.

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

17 (b-6) (Blank).

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

23 (b-8) Reimbursements to eligible airport sponsors for the  
24 construction or upgrading of Automated Weather Observation  
25 Systems may be made by the Department of Transportation from  
26 appropriations for those purposes for any fiscal year, without

1 regard to the fact that the qualification or obligation may  
2 have occurred in a prior fiscal year, provided that at the time  
3 the expenditure was made the project had been approved by the  
4 Department of Transportation prior to June 1, 2012 and, as a  
5 result of recent changes in federal funding formulas, can no  
6 longer receive federal reimbursement.

7 (b-9) (Blank).

8 (c) Further, payments may be made by the Department of  
9 Public Health and the Department of Human Services (acting as  
10 successor to the Department of Public Health under the  
11 Department of Human Services Act) from their respective  
12 appropriations for grants for medical care to or on behalf of  
13 premature and high-mortality risk infants and their mothers  
14 and for grants for supplemental food supplies provided under  
15 the United States Department of Agriculture Women, Infants and  
16 Children Nutrition Program, for any fiscal year without regard  
17 to the fact that the services being compensated for by such  
18 payment may have been rendered in a prior fiscal year, except  
19 as required by subsection (j) of this Section. Beginning on  
20 June 30, 2021, payments made by the Department of Public  
21 Health and the Department of Human Services from their  
22 respective appropriations for grants for medical care to or on  
23 behalf of premature and high-mortality risk infants and their  
24 mothers and for grants for supplemental food supplies provided  
25 under the United States Department of Agriculture Women,  
26 Infants and Children Nutrition Program payable from

1 appropriations that have otherwise expired may be paid out of  
2 the expiring appropriations during the 4-month period ending  
3 at the close of business on October 31.

4 (d) The Department of Public Health and the Department of  
5 Human Services (acting as successor to the Department of  
6 Public Health under the Department of Human Services Act)  
7 shall each annually submit to the State Comptroller, Senate  
8 President, Senate Minority Leader, Speaker of the House, House  
9 Minority Leader, and the respective Chairmen and Minority  
10 Spokesmen of the Appropriations Committees of the Senate and  
11 the House, on or before December 31, a report of fiscal year  
12 funds used to pay for services provided in any prior fiscal  
13 year. This report shall document by program or service  
14 category those expenditures from the most recently completed  
15 fiscal year used to pay for services provided in prior fiscal  
16 years.

17 (e) The Department of Healthcare and Family Services, the  
18 Department of Human Services (acting as successor to the  
19 Department of Public Aid), and the Department of Human  
20 Services making fee-for-service payments relating to substance  
21 abuse treatment services provided during a previous fiscal  
22 year shall each annually submit to the State Comptroller,  
23 Senate President, Senate Minority Leader, Speaker of the  
24 House, House Minority Leader, the respective Chairmen and  
25 Minority Spokesmen of the Appropriations Committees of the  
26 Senate and the House, on or before November 30, a report that

1 shall document by program or service category those  
2 expenditures from the most recently completed fiscal year used  
3 to pay for (i) services provided in prior fiscal years and (ii)  
4 services for which claims were received in prior fiscal years.

5 (f) The Department of Human Services (as successor to the  
6 Department of Public Aid) shall annually submit to the State  
7 Comptroller, Senate President, Senate Minority Leader, Speaker  
8 of the House, House Minority Leader, and the respective  
9 Chairmen and Minority Spokesmen of the Appropriations  
10 Committees of the Senate and the House, on or before December  
11 31, a report of fiscal year funds used to pay for services  
12 (other than medical care) provided in any prior fiscal year.  
13 This report shall document by program or service category  
14 those expenditures from the most recently completed fiscal  
15 year used to pay for services provided in prior fiscal years.

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

20 (1) Explanations of the exact causes of the variance  
21 between the previous year's estimated and actual  
22 liabilities.

23 (2) Factors affecting the Department of Healthcare and  
24 Family Services' liabilities, including, but not limited  
25 to, numbers of aid recipients, levels of medical service  
26 utilization by aid recipients, and inflation in the cost

1 of medical services.

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

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

10 (i) An agency which administers a fund classified by the  
11 Comptroller as an internal service fund may issue rules for:

12 (1) billing user agencies in advance for payments or  
13 authorized inter-fund transfers based on estimated charges  
14 for goods or services;

15 (2) issuing credits, refunding through inter-fund  
16 transfers, or reducing future inter-fund transfers during  
17 the subsequent fiscal year for all user agency payments or  
18 authorized inter-fund transfers received during the prior  
19 fiscal year which were in excess of the final amounts owed  
20 by the user agency for that period; and

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

26 User agencies are authorized to reimburse internal service

1 funds for catch-up billings by vouchers drawn against their  
2 respective appropriations for the fiscal year in which the  
3 catch-up billing was issued or by increasing an authorized  
4 inter-fund transfer during the current fiscal year. For the  
5 purposes of this Act, "inter-fund transfers" means transfers  
6 without the use of the voucher-warrant process, as authorized  
7 by Section 9.01 of the State Comptroller Act.

8 (i-1) Beginning on July 1, 2021, all outstanding  
9 liabilities, not payable during the 4-month lapse period as  
10 described in subsections (b-1), (b-3), (b-4), (b-5), and (c)  
11 of this Section, that are made from appropriations for that  
12 purpose for any fiscal year, without regard to the fact that  
13 the services being compensated for by those payments may have  
14 been rendered in a prior fiscal year, are limited to only those  
15 claims that have been incurred but for which a proper bill or  
16 invoice as defined by the State Prompt Payment Act has not been  
17 received by September 30th following the end of the fiscal  
18 year in which the service was rendered.

19 (j) Notwithstanding any other provision of this Act, the  
20 aggregate amount of payments to be made without regard for  
21 fiscal year limitations as contained in subsections (b-1),  
22 (b-3), (b-4), (b-5), and (c) of this Section, and determined  
23 by using Generally Accepted Accounting Principles, shall not  
24 exceed the following amounts:

25 (1) \$6,000,000,000 for outstanding liabilities related  
26 to fiscal year 2012;



1           (2) \$5,300,000,000 for outstanding liabilities related  
2 to fiscal year 2013;

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

5           (4) \$4,000,000,000 for outstanding liabilities related  
6 to fiscal year 2015;

7           (5) \$3,300,000,000 for outstanding liabilities related  
8 to fiscal year 2016;

9           (6) \$2,600,000,000 for outstanding liabilities related  
10 to fiscal year 2017;

11           (7) \$2,000,000,000 for outstanding liabilities related  
12 to fiscal year 2018;

13           (8) \$1,300,000,000 for outstanding liabilities related  
14 to fiscal year 2019;

15           (9) \$600,000,000 for outstanding liabilities related  
16 to fiscal year 2020; and

17           (10) \$0 for outstanding liabilities related to fiscal  
18 year 2021 and fiscal years thereafter.

19           (k) Department of Healthcare and Family Services Medical  
20 Assistance Payments.

21           (1) Definition of Medical Assistance.

22           For purposes of this subsection, the term "Medical  
23 Assistance" shall include, but not necessarily be  
24 limited to, medical programs and services authorized  
25 under Titles XIX and XXI of the Social Security Act,  
26 the Illinois Public Aid Code, ~~the Children's Health~~

1 ~~Insurance Program Act, the Covering ALL KIDS Health~~  
2 ~~Insurance Act,~~ the Long Term Acute Care Hospital  
3 Quality Improvement Transfer Program Act, and medical  
4 care to or on behalf of persons suffering from chronic  
5 renal disease, persons suffering from hemophilia, and  
6 victims of sexual assault.

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

9 (A) The maximum amounts of annual unpaid Medical  
10 Assistance bills received and recorded by the  
11 Department of Healthcare and Family Services on or  
12 before June 30th of a particular fiscal year  
13 attributable in aggregate to the General Revenue Fund,  
14 Healthcare Provider Relief Fund, Tobacco Settlement  
15 Recovery Fund, Long-Term Care Provider Fund, and the  
16 Drug Rebate Fund that may be paid in total by the  
17 Department from future fiscal year Medical Assistance  
18 appropriations to those funds are: \$700,000,000 for  
19 fiscal year 2013 and \$100,000,000 for fiscal year 2014  
20 and each fiscal year thereafter.

21 (B) Bills for Medical Assistance services rendered  
22 in a particular fiscal year, but received and recorded  
23 by the Department of Healthcare and Family Services  
24 after June 30th of that fiscal year, may be paid from  
25 either appropriations for that fiscal year or future  
26 fiscal year appropriations for Medical Assistance.

1           Such payments shall not be subject to the requirements  
2           of subparagraph (A).

3           (C) Medical Assistance bills received by the  
4           Department of Healthcare and Family Services in a  
5           particular fiscal year, but subject to payment amount  
6           adjustments in a future fiscal year may be paid from a  
7           future fiscal year's appropriation for Medical  
8           Assistance. Such payments shall not be subject to the  
9           requirements of subparagraph (A).

10          (D) Medical Assistance payments made by the  
11          Department of Healthcare and Family Services from  
12          funds other than those specifically referenced in  
13          subparagraph (A) may be made from appropriations for  
14          those purposes for any fiscal year without regard to  
15          the fact that the Medical Assistance services being  
16          compensated for by such payment may have been rendered  
17          in a prior fiscal year. Such payments shall not be  
18          subject to the requirements of subparagraph (A).

19          (3) Extended lapse period for Department of Healthcare  
20          and Family Services Medical Assistance payments.  
21          Notwithstanding any other State law to the contrary,  
22          outstanding Department of Healthcare and Family Services  
23          Medical Assistance liabilities, as of June 30th, payable  
24          from appropriations which have otherwise expired, may be  
25          paid out of the expiring appropriations during the 6-month  
26          period ending at the close of business on December 31st.

1           (1) The changes to this Section made by Public Act 97-691  
2 shall be effective for payment of Medical Assistance bills  
3 incurred in fiscal year 2013 and future fiscal years. The  
4 changes to this Section made by Public Act 97-691 shall not be  
5 applied to Medical Assistance bills incurred in fiscal year  
6 2012 or prior fiscal years.

7           (m) The Comptroller must issue payments against  
8 outstanding liabilities that were received prior to the lapse  
9 period deadlines set forth in this Section as soon thereafter  
10 as practical, but no payment may be issued after the 4 months  
11 following the lapse period deadline without the signed  
12 authorization of the Comptroller and the Governor.

13           (Source: P.A. 100-23, eff. 7-6-17; 100-587, eff. 6-4-18;  
14 101-10, eff. 6-5-19; 101-275, eff. 8-9-19; 101-636, eff.  
15 6-10-20.)

16           Section 10. The State Prompt Payment Act is amended by  
17 changing Section 3-2 as follows:

18           (30 ILCS 540/3-2)

19           Sec. 3-2. Beginning July 1, 1993, in any instance where a  
20 State official or agency is late in payment of a vendor's bill  
21 or invoice for goods or services furnished to the State, as  
22 defined in Section 1, properly approved in accordance with  
23 rules promulgated under Section 3-3, the State official or  
24 agency shall pay interest to the vendor in accordance with the

1 following:

2 (1) Any bill, except a bill submitted under Article V  
3 of the Illinois Public Aid Code and except as provided  
4 under paragraph (1.05) of this Section, approved for  
5 payment under this Section must be paid or the payment  
6 issued to the payee within 60 days of receipt of a proper  
7 bill or invoice. If payment is not issued to the payee  
8 within this 60-day period, an interest penalty of 1.0% of  
9 any amount approved and unpaid shall be added for each  
10 month or fraction thereof after the end of this 60-day  
11 period, until final payment is made. Any bill, except a  
12 bill for pharmacy or nursing facility services or goods,  
13 and except as provided under paragraph (1.05) of this  
14 Section, submitted under Article V of the Illinois Public  
15 Aid Code approved for payment under this Section must be  
16 paid or the payment issued to the payee within 60 days  
17 after receipt of a proper bill or invoice, and, if payment  
18 is not issued to the payee within this 60-day period, an  
19 interest penalty of 2.0% of any amount approved and unpaid  
20 shall be added for each month or fraction thereof after  
21 the end of this 60-day period, until final payment is  
22 made. Any bill for pharmacy or nursing facility services  
23 or goods submitted under Article V of the Illinois Public  
24 Aid Code, except as provided under paragraph (1.05) of  
25 this Section, and approved for payment under this Section  
26 must be paid or the payment issued to the payee within 60

1 days of receipt of a proper bill or invoice. If payment is  
2 not issued to the payee within this 60-day period, an  
3 interest penalty of 1.0% of any amount approved and unpaid  
4 shall be added for each month or fraction thereof after  
5 the end of this 60-day period, until final payment is  
6 made.

7 (1.05) For State fiscal year 2012 and future fiscal  
8 years, any bill approved for payment under this Section  
9 must be paid or the payment issued to the payee within 90  
10 days of receipt of a proper bill or invoice. If payment is  
11 not issued to the payee within this 90-day period, an  
12 interest penalty of 1.0% of any amount approved and unpaid  
13 shall be added for each month, or 0.033% (one-thirtieth of  
14 one percent) of any amount approved and unpaid for each  
15 day, after the end of this 90-day period, until final  
16 payment is made.

17 (1.1) A State agency shall review in a timely manner  
18 each bill or invoice after its receipt. If the State  
19 agency determines that the bill or invoice contains a  
20 defect making it unable to process the payment request,  
21 the agency shall notify the vendor requesting payment as  
22 soon as possible after discovering the defect pursuant to  
23 rules promulgated under Section 3-3; provided, however,  
24 that the notice for construction related bills or invoices  
25 must be given not later than 30 days after the bill or  
26 invoice was first submitted. The notice shall identify the

1 defect and any additional information necessary to correct  
2 the defect. If one or more items on a construction related  
3 bill or invoice are disapproved, but not the entire bill  
4 or invoice, then the portion that is not disapproved shall  
5 be paid.

6 (2) Where a State official or agency is late in  
7 payment of a vendor's bill or invoice properly approved in  
8 accordance with this Act, and different late payment terms  
9 are not reduced to writing as a contractual agreement, the  
10 State official or agency shall automatically pay interest  
11 penalties required by this Section amounting to \$50 or  
12 more to the appropriate vendor. Each agency shall be  
13 responsible for determining whether an interest penalty is  
14 owed and for paying the interest to the vendor. Except as  
15 provided in paragraph (4), an individual interest payment  
16 amounting to \$5 or less shall not be paid by the State.  
17 Interest due to a vendor that amounts to greater than \$5  
18 and less than \$50 shall not be paid but shall be accrued  
19 until all interest due the vendor for all similar warrants  
20 exceeds \$50, at which time the accrued interest shall be  
21 payable and interest will begin accruing again, except  
22 that interest accrued as of the end of the fiscal year that  
23 does not exceed \$50 shall be payable at that time. In the  
24 event an individual has paid a vendor for services in  
25 advance, the provisions of this Section shall apply until  
26 payment is made to that individual.

1           (3) The provisions of Public Act 96-1501 reducing the  
2 interest rate on pharmacy claims under Article V of the  
3 Illinois Public Aid Code to 1.0% per month shall apply to  
4 any pharmacy bills for services and goods under Article V  
5 of the Illinois Public Aid Code received on or after the  
6 date 60 days before January 25, 2011 (the effective date  
7 of Public Act 96-1501) except as provided under paragraph  
8 (1.05) of this Section.

9           (4) Interest amounting to less than \$5 shall not be  
10 paid by the State, except for claims (i) to the Department  
11 of Healthcare and Family Services or the Department of  
12 Human Services, (ii) pursuant to Article V of the Illinois  
13 Public Aid Code, ~~the Covering ALL KIDS Health Insurance~~  
14 ~~Act, or the Children's Health Insurance Program Act,~~ and  
15 (iii) made (A) by pharmacies for prescriptive services or  
16 (B) by any federally qualified health center for  
17 prescriptive services or any other services.

18           Notwithstanding any provision to the contrary, interest  
19 may not be paid under this Act when: (1) a Chief Procurement  
20 Officer has voided the underlying contract for goods or  
21 services under Article 50 of the Illinois Procurement Code; or  
22 (2) the Auditor General is conducting a performance or program  
23 audit and the Comptroller has held or is holding for review a  
24 related contract or vouchers for payment of goods or services  
25 in the exercise of duties under Section 9 of the State  
26 Comptroller Act. In such event, interest shall not accrue



1 during the pendency of the Auditor General's review.

2 (Source: P.A. 100-1064, eff. 8-24-18.)

3 Section 15. The Use Tax Act is amended by changing Section  
4 3-8 as follows:

5 (35 ILCS 105/3-8)

6 Sec. 3-8. Hospital exemption.

7 (a) Until July 1, 2022, tangible personal property sold to  
8 or used by a hospital owner that owns one or more hospitals  
9 licensed under the Hospital Licensing Act or operated under  
10 the University of Illinois Hospital Act, or a hospital  
11 affiliate that is not already exempt under another provision  
12 of this Act and meets the criteria for an exemption under this  
13 Section, is exempt from taxation under this Act.

14 (b) A hospital owner or hospital affiliate satisfies the  
15 conditions for an exemption under this Section if the value of  
16 qualified services or activities listed in subsection (c) of  
17 this Section for the hospital year equals or exceeds the  
18 relevant hospital entity's estimated property tax liability,  
19 without regard to any property tax exemption granted under  
20 Section 15-86 of the Property Tax Code, for the calendar year  
21 in which exemption or renewal of exemption is sought. For  
22 purposes of making the calculations required by this  
23 subsection (b), if the relevant hospital entity is a hospital  
24 owner that owns more than one hospital, the value of the

1 services or activities listed in subsection (c) shall be  
2 calculated on the basis of only those services and activities  
3 relating to the hospital that includes the subject property,  
4 and the relevant hospital entity's estimated property tax  
5 liability shall be calculated only with respect to the  
6 properties comprising that hospital. In the case of a  
7 multi-state hospital system or hospital affiliate, the value  
8 of the services or activities listed in subsection (c) shall  
9 be calculated on the basis of only those services and  
10 activities that occur in Illinois and the relevant hospital  
11 entity's estimated property tax liability shall be calculated  
12 only with respect to its property located in Illinois.

13 (c) The following services and activities shall be  
14 considered for purposes of making the calculations required by  
15 subsection (b):

16 (1) Charity care. Free or discounted services provided  
17 pursuant to the relevant hospital entity's financial  
18 assistance policy, measured at cost, including discounts  
19 provided under the Hospital Uninsured Patient Discount  
20 Act.

21 (2) Health services to low-income and underserved  
22 individuals. Other unreimbursed costs of the relevant  
23 hospital entity for providing without charge, paying for,  
24 or subsidizing goods, activities, or services for the  
25 purpose of addressing the health of low-income or  
26 underserved individuals. Those activities or services may

1 include, but are not limited to: financial or in-kind  
2 support to affiliated or unaffiliated hospitals, hospital  
3 affiliates, community clinics, or programs that treat  
4 low-income or underserved individuals; paying for or  
5 subsidizing health care professionals who care for  
6 low-income or underserved individuals; providing or  
7 subsidizing outreach or educational services to low-income  
8 or underserved individuals for disease management and  
9 prevention; free or subsidized goods, supplies, or  
10 services needed by low-income or underserved individuals  
11 because of their medical condition; and prenatal or  
12 childbirth outreach to low-income or underserved persons.

13 (3) Subsidy of State or local governments. Direct or  
14 indirect financial or in-kind subsidies of State or local  
15 governments by the relevant hospital entity that pay for  
16 or subsidize activities or programs related to health care  
17 for low-income or underserved individuals.

18 (4) Support for State health care programs for  
19 low-income individuals. At the election of the hospital  
20 applicant for each applicable year, either (A) 10% of  
21 payments to the relevant hospital entity and any hospital  
22 affiliate designated by the relevant hospital entity  
23 (provided that such hospital affiliate's operations  
24 provide financial or operational support for or receive  
25 financial or operational support from the relevant  
26 hospital entity) under Medicaid or other means-tested

1 programs, including, but not limited to, General  
2 Assistance, ~~the Covering ALL KIDS Health Insurance Act,~~  
3 ~~and the State Children's Health Insurance Program~~ or (B)  
4 the amount of subsidy provided by the relevant hospital  
5 entity and any hospital affiliate designated by the  
6 relevant hospital entity (provided that such hospital  
7 affiliate's operations provide financial or operational  
8 support for or receive financial or operational support  
9 from the relevant hospital entity) to State or local  
10 government in treating Medicaid recipients and recipients  
11 of means-tested programs, including but not limited to  
12 General Assistance, ~~the Covering ALL KIDS Health Insurance~~  
13 ~~Act, and the State Children's Health Insurance Program.~~  
14 The amount of subsidy for purpose of this item (4) is  
15 calculated in the same manner as unreimbursed costs are  
16 calculated for Medicaid and other means-tested government  
17 programs in the Schedule H of IRS Form 990 in effect on the  
18 effective date of this amendatory Act of the 97th General  
19 Assembly.

20 (5) Dual-eligible subsidy. The amount of subsidy  
21 provided to government by treating dual-eligible  
22 Medicare/Medicaid patients. The amount of subsidy for  
23 purposes of this item (5) is calculated by multiplying the  
24 relevant hospital entity's unreimbursed costs for  
25 Medicare, calculated in the same manner as determined in  
26 the Schedule H of IRS Form 990 in effect on the effective

1 date of this amendatory Act of the 97th General Assembly,  
2 by the relevant hospital entity's ratio of dual-eligible  
3 patients to total Medicare patients.

4 (6) Relief of the burden of government related to  
5 health care. Except to the extent otherwise taken into  
6 account in this subsection, the portion of unreimbursed  
7 costs of the relevant hospital entity attributable to  
8 providing, paying for, or subsidizing goods, activities,  
9 or services that relieve the burden of government related  
10 to health care for low-income individuals. Such activities  
11 or services shall include, but are not limited to,  
12 providing emergency, trauma, burn, neonatal, psychiatric,  
13 rehabilitation, or other special services; providing  
14 medical education; and conducting medical research or  
15 training of health care professionals. The portion of  
16 those unreimbursed costs attributable to benefiting  
17 low-income individuals shall be determined using the ratio  
18 calculated by adding the relevant hospital entity's costs  
19 attributable to charity care, Medicaid, other means-tested  
20 government programs, Medicare patients with disabilities  
21 under age 65, and dual-eligible Medicare/Medicaid patients  
22 and dividing that total by the relevant hospital entity's  
23 total costs. Such costs for the numerator and denominator  
24 shall be determined by multiplying gross charges by the  
25 cost to charge ratio taken from the hospital's most  
26 recently filed Medicare cost report (CMS 2252-10

1           Worksheet, Part I). In the case of emergency services, the  
2           ratio shall be calculated using costs (gross charges  
3           multiplied by the cost to charge ratio taken from the  
4           hospital's most recently filed Medicare cost report (CMS  
5           2252-10 Worksheet, Part I)) of patients treated in the  
6           relevant hospital entity's emergency department.

7           (7) Any other activity by the relevant hospital entity  
8           that the Department determines relieves the burden of  
9           government or addresses the health of low-income or  
10          underserved individuals.

11          (d) The hospital applicant shall include information in  
12          its exemption application establishing that it satisfies the  
13          requirements of subsection (b). For purposes of making the  
14          calculations required by subsection (b), the hospital  
15          applicant may for each year elect to use either (1) the value  
16          of the services or activities listed in subsection (e) for the  
17          hospital year or (2) the average value of those services or  
18          activities for the 3 fiscal years ending with the hospital  
19          year. If the relevant hospital entity has been in operation  
20          for less than 3 completed fiscal years, then the latter  
21          calculation, if elected, shall be performed on a pro rata  
22          basis.

23          (e) For purposes of making the calculations required by  
24          this Section:

25                 (1) particular services or activities eligible for  
26                 consideration under any of the paragraphs (1) through (7)

1 of subsection (c) may not be counted under more than one of  
2 those paragraphs; and

3 (2) the amount of unreimbursed costs and the amount of  
4 subsidy shall not be reduced by restricted or unrestricted  
5 payments received by the relevant hospital entity as  
6 contributions deductible under Section 170(a) of the  
7 Internal Revenue Code.

8 (f) (Blank).

9 (g) Estimation of Exempt Property Tax Liability. The  
10 estimated property tax liability used for the determination in  
11 subsection (b) shall be calculated as follows:

12 (1) "Estimated property tax liability" means the  
13 estimated dollar amount of property tax that would be  
14 owed, with respect to the exempt portion of each of the  
15 relevant hospital entity's properties that are already  
16 fully or partially exempt, or for which an exemption in  
17 whole or in part is currently being sought, and then  
18 aggregated as applicable, as if the exempt portion of  
19 those properties were subject to tax, calculated with  
20 respect to each such property by multiplying:

21 (A) the lesser of (i) the actual assessed value,  
22 if any, of the portion of the property for which an  
23 exemption is sought or (ii) an estimated assessed  
24 value of the exempt portion of such property as  
25 determined in item (2) of this subsection (g), by

26 (B) the applicable State equalization rate

1 (yielding the equalized assessed value), by

2 (C) the applicable tax rate.

3 (2) The estimated assessed value of the exempt portion  
4 of the property equals the sum of (i) the estimated fair  
5 market value of buildings on the property, as determined  
6 in accordance with subparagraphs (A) and (B) of this item  
7 (2), multiplied by the applicable assessment factor, and  
8 (ii) the estimated assessed value of the land portion of  
9 the property, as determined in accordance with  
10 subparagraph (C).

11 (A) The "estimated fair market value of buildings  
12 on the property" means the replacement value of any  
13 exempt portion of buildings on the property, minus  
14 depreciation, determined utilizing the cost  
15 replacement method whereby the exempt square footage  
16 of all such buildings is multiplied by the replacement  
17 cost per square foot for Class A Average building  
18 found in the most recent edition of the Marshall &  
19 Swift Valuation Services Manual, adjusted by any  
20 appropriate current cost and local multipliers.

21 (B) Depreciation, for purposes of calculating the  
22 estimated fair market value of buildings on the  
23 property, is applied by utilizing a weighted mean life  
24 for the buildings based on original construction and  
25 assuming a 40-year life for hospital buildings and the  
26 applicable life for other types of buildings as



1 specified in the American Hospital Association  
2 publication "Estimated Useful Lives of Depreciable  
3 Hospital Assets". In the case of hospital buildings,  
4 the remaining life is divided by 40 and this ratio is  
5 multiplied by the replacement cost of the buildings to  
6 obtain an estimated fair market value of buildings. If  
7 a hospital building is older than 35 years, a  
8 remaining life of 5 years for residual value is  
9 assumed; and if a building is less than 8 years old, a  
10 remaining life of 32 years is assumed.

11 (C) The estimated assessed value of the land  
12 portion of the property shall be determined by  
13 multiplying (i) the per square foot average of the  
14 assessed values of three parcels of land (not  
15 including farm land, and excluding the assessed value  
16 of the improvements thereon) reasonably comparable to  
17 the property, by (ii) the number of square feet  
18 comprising the exempt portion of the property's land  
19 square footage.

20 (3) The assessment factor, State equalization rate,  
21 and tax rate (including any special factors such as  
22 Enterprise Zones) used in calculating the estimated  
23 property tax liability shall be for the most recent year  
24 that is publicly available from the applicable chief  
25 county assessment officer or officers at least 90 days  
26 before the end of the hospital year.

1           (4) The method utilized to calculate estimated  
2 property tax liability for purposes of this Section 15-86  
3 shall not be utilized for the actual valuation,  
4 assessment, or taxation of property pursuant to the  
5 Property Tax Code.

6           (h) For the purpose of this Section, the following terms  
7 shall have the meanings set forth below:

8           (1) "Hospital" means any institution, place, building,  
9 buildings on a campus, or other health care facility  
10 located in Illinois that is licensed under the Hospital  
11 Licensing Act and has a hospital owner.

12           (2) "Hospital owner" means a not-for-profit  
13 corporation that is the titleholder of a hospital, or the  
14 owner of the beneficial interest in an Illinois land trust  
15 that is the titleholder of a hospital.

16           (3) "Hospital affiliate" means any corporation,  
17 partnership, limited partnership, joint venture, limited  
18 liability company, association or other organization,  
19 other than a hospital owner, that directly or indirectly  
20 controls, is controlled by, or is under common control  
21 with one or more hospital owners and that supports, is  
22 supported by, or acts in furtherance of the exempt health  
23 care purposes of at least one of those hospital owners'  
24 hospitals.

25           (4) "Hospital system" means a hospital and one or more  
26 other hospitals or hospital affiliates related by common

1 control or ownership.

2 (5) "Control" relating to hospital owners, hospital  
3 affiliates, or hospital systems means possession, direct  
4 or indirect, of the power to direct or cause the direction  
5 of the management and policies of the entity, whether  
6 through ownership of assets, membership interest, other  
7 voting or governance rights, by contract or otherwise.

8 (6) "Hospital applicant" means a hospital owner or  
9 hospital affiliate that files an application for an  
10 exemption or renewal of exemption under this Section.

11 (7) "Relevant hospital entity" means (A) the hospital  
12 owner, in the case of a hospital applicant that is a  
13 hospital owner, and (B) at the election of a hospital  
14 applicant that is a hospital affiliate, either (i) the  
15 hospital affiliate or (ii) the hospital system to which  
16 the hospital applicant belongs, including any hospitals or  
17 hospital affiliates that are related by common control or  
18 ownership.

19 (8) "Subject property" means property used for the  
20 calculation under subsection (b) of this Section.

21 (9) "Hospital year" means the fiscal year of the  
22 relevant hospital entity, or the fiscal year of one of the  
23 hospital owners in the hospital system if the relevant  
24 hospital entity is a hospital system with members with  
25 different fiscal years, that ends in the year for which  
26 the exemption is sought.

1 (i) It is the intent of the General Assembly that any  
2 exemptions taken, granted, or renewed under this Section prior  
3 to the effective date of this amendatory Act of the 100th  
4 General Assembly are hereby validated.

5 (Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

6 Section 20. The Service Use Tax Act is amended by changing  
7 Section 3-8 as follows:

8 (35 ILCS 110/3-8)

9 Sec. 3-8. Hospital exemption.

10 (a) Until July 1, 2022, tangible personal property sold to  
11 or used by a hospital owner that owns one or more hospitals  
12 licensed under the Hospital Licensing Act or operated under  
13 the University of Illinois Hospital Act, or a hospital  
14 affiliate that is not already exempt under another provision  
15 of this Act and meets the criteria for an exemption under this  
16 Section, is exempt from taxation under this Act.

17 (b) A hospital owner or hospital affiliate satisfies the  
18 conditions for an exemption under this Section if the value of  
19 qualified services or activities listed in subsection (c) of  
20 this Section for the hospital year equals or exceeds the  
21 relevant hospital entity's estimated property tax liability,  
22 without regard to any property tax exemption granted under  
23 Section 15-86 of the Property Tax Code, for the calendar year  
24 in which exemption or renewal of exemption is sought. For

1 purposes of making the calculations required by this  
2 subsection (b), if the relevant hospital entity is a hospital  
3 owner that owns more than one hospital, the value of the  
4 services or activities listed in subsection (c) shall be  
5 calculated on the basis of only those services and activities  
6 relating to the hospital that includes the subject property,  
7 and the relevant hospital entity's estimated property tax  
8 liability shall be calculated only with respect to the  
9 properties comprising that hospital. In the case of a  
10 multi-state hospital system or hospital affiliate, the value  
11 of the services or activities listed in subsection (c) shall  
12 be calculated on the basis of only those services and  
13 activities that occur in Illinois and the relevant hospital  
14 entity's estimated property tax liability shall be calculated  
15 only with respect to its property located in Illinois.

16 (c) The following services and activities shall be  
17 considered for purposes of making the calculations required by  
18 subsection (b):

19 (1) Charity care. Free or discounted services provided  
20 pursuant to the relevant hospital entity's financial  
21 assistance policy, measured at cost, including discounts  
22 provided under the Hospital Uninsured Patient Discount  
23 Act.

24 (2) Health services to low-income and underserved  
25 individuals. Other unreimbursed costs of the relevant  
26 hospital entity for providing without charge, paying for,

1 or subsidizing goods, activities, or services for the  
2 purpose of addressing the health of low-income or  
3 underserved individuals. Those activities or services may  
4 include, but are not limited to: financial or in-kind  
5 support to affiliated or unaffiliated hospitals, hospital  
6 affiliates, community clinics, or programs that treat  
7 low-income or underserved individuals; paying for or  
8 subsidizing health care professionals who care for  
9 low-income or underserved individuals; providing or  
10 subsidizing outreach or educational services to low-income  
11 or underserved individuals for disease management and  
12 prevention; free or subsidized goods, supplies, or  
13 services needed by low-income or underserved individuals  
14 because of their medical condition; and prenatal or  
15 childbirth outreach to low-income or underserved persons.

16 (3) Subsidy of State or local governments. Direct or  
17 indirect financial or in-kind subsidies of State or local  
18 governments by the relevant hospital entity that pay for  
19 or subsidize activities or programs related to health care  
20 for low-income or underserved individuals.

21 (4) Support for State health care programs for  
22 low-income individuals. At the election of the hospital  
23 applicant for each applicable year, either (A) 10% of  
24 payments to the relevant hospital entity and any hospital  
25 affiliate designated by the relevant hospital entity  
26 (provided that such hospital affiliate's operations

1 provide financial or operational support for or receive  
2 financial or operational support from the relevant  
3 hospital entity) under Medicaid or other means-tested  
4 programs, including, but not limited to, General  
5 Assistance, ~~the Covering ALL KIDS Health Insurance Act,~~  
6 ~~and the State Children's Health Insurance Program~~ or (B)  
7 the amount of subsidy provided by the relevant hospital  
8 entity and any hospital affiliate designated by the  
9 relevant hospital entity (provided that such hospital  
10 affiliate's operations provide financial or operational  
11 support for or receive financial or operational support  
12 from the relevant hospital entity) to State or local  
13 government in treating Medicaid recipients and recipients  
14 of means-tested programs, including but not limited to  
15 General Assistance, ~~the Covering ALL KIDS Health Insurance~~  
16 ~~Act, and the State Children's Health Insurance Program.~~  
17 The amount of subsidy for purposes of this item (4) is  
18 calculated in the same manner as unreimbursed costs are  
19 calculated for Medicaid and other means-tested government  
20 programs in the Schedule H of IRS Form 990 in effect on the  
21 effective date of this amendatory Act of the 97th General  
22 Assembly.

23 (5) Dual-eligible subsidy. The amount of subsidy  
24 provided to government by treating dual-eligible  
25 Medicare/Medicaid patients. The amount of subsidy for  
26 purposes of this item (5) is calculated by multiplying the

1 relevant hospital entity's unreimbursed costs for  
2 Medicare, calculated in the same manner as determined in  
3 the Schedule H of IRS Form 990 in effect on the effective  
4 date of this amendatory Act of the 97th General Assembly,  
5 by the relevant hospital entity's ratio of dual-eligible  
6 patients to total Medicare patients.

7 (6) Relief of the burden of government related to  
8 health care. Except to the extent otherwise taken into  
9 account in this subsection, the portion of unreimbursed  
10 costs of the relevant hospital entity attributable to  
11 providing, paying for, or subsidizing goods, activities,  
12 or services that relieve the burden of government related  
13 to health care for low-income individuals. Such activities  
14 or services shall include, but are not limited to,  
15 providing emergency, trauma, burn, neonatal, psychiatric,  
16 rehabilitation, or other special services; providing  
17 medical education; and conducting medical research or  
18 training of health care professionals. The portion of  
19 those unreimbursed costs attributable to benefiting  
20 low-income individuals shall be determined using the ratio  
21 calculated by adding the relevant hospital entity's costs  
22 attributable to charity care, Medicaid, other means-tested  
23 government programs, Medicare patients with disabilities  
24 under age 65, and dual-eligible Medicare/Medicaid patients  
25 and dividing that total by the relevant hospital entity's  
26 total costs. Such costs for the numerator and denominator



1 shall be determined by multiplying gross charges by the  
2 cost to charge ratio taken from the hospital's most  
3 recently filed Medicare cost report (CMS 2252-10  
4 Worksheet, Part I). In the case of emergency services, the  
5 ratio shall be calculated using costs (gross charges  
6 multiplied by the cost to charge ratio taken from the  
7 hospital's most recently filed Medicare cost report (CMS  
8 2252-10 Worksheet, Part I)) of patients treated in the  
9 relevant hospital entity's emergency department.

10 (7) Any other activity by the relevant hospital entity  
11 that the Department determines relieves the burden of  
12 government or addresses the health of low-income or  
13 underserved individuals.

14 (d) The hospital applicant shall include information in  
15 its exemption application establishing that it satisfies the  
16 requirements of subsection (b). For purposes of making the  
17 calculations required by subsection (b), the hospital  
18 applicant may for each year elect to use either (1) the value  
19 of the services or activities listed in subsection (e) for the  
20 hospital year or (2) the average value of those services or  
21 activities for the 3 fiscal years ending with the hospital  
22 year. If the relevant hospital entity has been in operation  
23 for less than 3 completed fiscal years, then the latter  
24 calculation, if elected, shall be performed on a pro rata  
25 basis.

26 (e) For purposes of making the calculations required by

1 this Section:

2 (1) particular services or activities eligible for  
3 consideration under any of the paragraphs (1) through (7)  
4 of subsection (c) may not be counted under more than one of  
5 those paragraphs; and

6 (2) the amount of unreimbursed costs and the amount of  
7 subsidy shall not be reduced by restricted or unrestricted  
8 payments received by the relevant hospital entity as  
9 contributions deductible under Section 170(a) of the  
10 Internal Revenue Code.

11 (f) (Blank).

12 (g) Estimation of Exempt Property Tax Liability. The  
13 estimated property tax liability used for the determination in  
14 subsection (b) shall be calculated as follows:

15 (1) "Estimated property tax liability" means the  
16 estimated dollar amount of property tax that would be  
17 owed, with respect to the exempt portion of each of the  
18 relevant hospital entity's properties that are already  
19 fully or partially exempt, or for which an exemption in  
20 whole or in part is currently being sought, and then  
21 aggregated as applicable, as if the exempt portion of  
22 those properties were subject to tax, calculated with  
23 respect to each such property by multiplying:

24 (A) the lesser of (i) the actual assessed value,  
25 if any, of the portion of the property for which an  
26 exemption is sought or (ii) an estimated assessed

1 value of the exempt portion of such property as  
2 determined in item (2) of this subsection (g), by

3 (B) the applicable State equalization rate  
4 (yielding the equalized assessed value), by

5 (C) the applicable tax rate.

6 (2) The estimated assessed value of the exempt portion  
7 of the property equals the sum of (i) the estimated fair  
8 market value of buildings on the property, as determined  
9 in accordance with subparagraphs (A) and (B) of this item  
10 (2), multiplied by the applicable assessment factor, and  
11 (ii) the estimated assessed value of the land portion of  
12 the property, as determined in accordance with  
13 subparagraph (C).

14 (A) The "estimated fair market value of buildings  
15 on the property" means the replacement value of any  
16 exempt portion of buildings on the property, minus  
17 depreciation, determined utilizing the cost  
18 replacement method whereby the exempt square footage  
19 of all such buildings is multiplied by the replacement  
20 cost per square foot for Class A Average building  
21 found in the most recent edition of the Marshall &  
22 Swift Valuation Services Manual, adjusted by any  
23 appropriate current cost and local multipliers.

24 (B) Depreciation, for purposes of calculating the  
25 estimated fair market value of buildings on the  
26 property, is applied by utilizing a weighted mean life

1 for the buildings based on original construction and  
2 assuming a 40-year life for hospital buildings and the  
3 applicable life for other types of buildings as  
4 specified in the American Hospital Association  
5 publication "Estimated Useful Lives of Depreciable  
6 Hospital Assets". In the case of hospital buildings,  
7 the remaining life is divided by 40 and this ratio is  
8 multiplied by the replacement cost of the buildings to  
9 obtain an estimated fair market value of buildings. If  
10 a hospital building is older than 35 years, a  
11 remaining life of 5 years for residual value is  
12 assumed; and if a building is less than 8 years old, a  
13 remaining life of 32 years is assumed.

14 (C) The estimated assessed value of the land  
15 portion of the property shall be determined by  
16 multiplying (i) the per square foot average of the  
17 assessed values of three parcels of land (not  
18 including farm land, and excluding the assessed value  
19 of the improvements thereon) reasonably comparable to  
20 the property, by (ii) the number of square feet  
21 comprising the exempt portion of the property's land  
22 square footage.

23 (3) The assessment factor, State equalization rate,  
24 and tax rate (including any special factors such as  
25 Enterprise Zones) used in calculating the estimated  
26 property tax liability shall be for the most recent year

1 that is publicly available from the applicable chief  
2 county assessment officer or officers at least 90 days  
3 before the end of the hospital year.

4 (4) The method utilized to calculate estimated  
5 property tax liability for purposes of this Section 15-86  
6 shall not be utilized for the actual valuation,  
7 assessment, or taxation of property pursuant to the  
8 Property Tax Code.

9 (h) For the purpose of this Section, the following terms  
10 shall have the meanings set forth below:

11 (1) "Hospital" means any institution, place, building,  
12 buildings on a campus, or other health care facility  
13 located in Illinois that is licensed under the Hospital  
14 Licensing Act and has a hospital owner.

15 (2) "Hospital owner" means a not-for-profit  
16 corporation that is the titleholder of a hospital, or the  
17 owner of the beneficial interest in an Illinois land trust  
18 that is the titleholder of a hospital.

19 (3) "Hospital affiliate" means any corporation,  
20 partnership, limited partnership, joint venture, limited  
21 liability company, association or other organization,  
22 other than a hospital owner, that directly or indirectly  
23 controls, is controlled by, or is under common control  
24 with one or more hospital owners and that supports, is  
25 supported by, or acts in furtherance of the exempt health  
26 care purposes of at least one of those hospital owners'

1 hospitals.

2 (4) "Hospital system" means a hospital and one or more  
3 other hospitals or hospital affiliates related by common  
4 control or ownership.

5 (5) "Control" relating to hospital owners, hospital  
6 affiliates, or hospital systems means possession, direct  
7 or indirect, of the power to direct or cause the direction  
8 of the management and policies of the entity, whether  
9 through ownership of assets, membership interest, other  
10 voting or governance rights, by contract or otherwise.

11 (6) "Hospital applicant" means a hospital owner or  
12 hospital affiliate that files an application for an  
13 exemption or renewal of exemption under this Section.

14 (7) "Relevant hospital entity" means (A) the hospital  
15 owner, in the case of a hospital applicant that is a  
16 hospital owner, and (B) at the election of a hospital  
17 applicant that is a hospital affiliate, either (i) the  
18 hospital affiliate or (ii) the hospital system to which  
19 the hospital applicant belongs, including any hospitals or  
20 hospital affiliates that are related by common control or  
21 ownership.

22 (8) "Subject property" means property used for the  
23 calculation under subsection (b) of this Section.

24 (9) "Hospital year" means the fiscal year of the  
25 relevant hospital entity, or the fiscal year of one of the  
26 hospital owners in the hospital system if the relevant

1 hospital entity is a hospital system with members with  
2 different fiscal years, that ends in the year for which  
3 the exemption is sought.

4 (i) It is the intent of the General Assembly that any  
5 exemptions taken, granted, or renewed under this Section prior  
6 to the effective date of this amendatory Act of the 100th  
7 General Assembly are hereby validated.

8 (Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

9 Section 25. The Retailers' Occupation Tax Act is amended  
10 by changing Section 2-9 as follows:

11 (35 ILCS 120/2-9)

12 Sec. 2-9. Hospital exemption.

13 (a) Until July 1, 2022, tangible personal property sold to  
14 or used by a hospital owner that owns one or more hospitals  
15 licensed under the Hospital Licensing Act or operated under  
16 the University of Illinois Hospital Act, or a hospital  
17 affiliate that is not already exempt under another provision  
18 of this Act and meets the criteria for an exemption under this  
19 Section, is exempt from taxation under this Act.

20 (b) A hospital owner or hospital affiliate satisfies the  
21 conditions for an exemption under this Section if the value of  
22 qualified services or activities listed in subsection (c) of  
23 this Section for the hospital year equals or exceeds the  
24 relevant hospital entity's estimated property tax liability,

1 without regard to any property tax exemption granted under  
2 Section 15-86 of the Property Tax Code, for the calendar year  
3 in which exemption or renewal of exemption is sought. For  
4 purposes of making the calculations required by this  
5 subsection (b), if the relevant hospital entity is a hospital  
6 owner that owns more than one hospital, the value of the  
7 services or activities listed in subsection (c) shall be  
8 calculated on the basis of only those services and activities  
9 relating to the hospital that includes the subject property,  
10 and the relevant hospital entity's estimated property tax  
11 liability shall be calculated only with respect to the  
12 properties comprising that hospital. In the case of a  
13 multi-state hospital system or hospital affiliate, the value  
14 of the services or activities listed in subsection (c) shall  
15 be calculated on the basis of only those services and  
16 activities that occur in Illinois and the relevant hospital  
17 entity's estimated property tax liability shall be calculated  
18 only with respect to its property located in Illinois.

19 (c) The following services and activities shall be  
20 considered for purposes of making the calculations required by  
21 subsection (b):

22 (1) Charity care. Free or discounted services provided  
23 pursuant to the relevant hospital entity's financial  
24 assistance policy, measured at cost, including discounts  
25 provided under the Hospital Uninsured Patient Discount  
26 Act.



1           (2) Health services to low-income and underserved  
2 individuals. Other unreimbursed costs of the relevant  
3 hospital entity for providing without charge, paying for,  
4 or subsidizing goods, activities, or services for the  
5 purpose of addressing the health of low-income or  
6 underserved individuals. Those activities or services may  
7 include, but are not limited to: financial or in-kind  
8 support to affiliated or unaffiliated hospitals, hospital  
9 affiliates, community clinics, or programs that treat  
10 low-income or underserved individuals; paying for or  
11 subsidizing health care professionals who care for  
12 low-income or underserved individuals; providing or  
13 subsidizing outreach or educational services to low-income  
14 or underserved individuals for disease management and  
15 prevention; free or subsidized goods, supplies, or  
16 services needed by low-income or underserved individuals  
17 because of their medical condition; and prenatal or  
18 childbirth outreach to low-income or underserved persons.

19           (3) Subsidy of State or local governments. Direct or  
20 indirect financial or in-kind subsidies of State or local  
21 governments by the relevant hospital entity that pay for  
22 or subsidize activities or programs related to health care  
23 for low-income or underserved individuals.

24           (4) Support for State health care programs for  
25 low-income individuals. At the election of the hospital  
26 applicant for each applicable year, either (A) 10% of

1 payments to the relevant hospital entity and any hospital  
2 affiliate designated by the relevant hospital entity  
3 (provided that such hospital affiliate's operations  
4 provide financial or operational support for or receive  
5 financial or operational support from the relevant  
6 hospital entity) under Medicaid or other means-tested  
7 programs, including, but not limited to, General  
8 Assistance, ~~the Covering ALL KIDS Health Insurance Act,~~  
9 ~~and the State Children's Health Insurance Program~~ or (B)  
10 the amount of subsidy provided by the relevant hospital  
11 entity and any hospital affiliate designated by the  
12 relevant hospital entity (provided that such hospital  
13 affiliate's operations provide financial or operational  
14 support for or receive financial or operational support  
15 from the relevant hospital entity) to State or local  
16 government in treating Medicaid recipients and recipients  
17 of means-tested programs, including but not limited to  
18 General Assistance, ~~the Covering ALL KIDS Health Insurance~~  
19 ~~Act, and the State Children's Health Insurance Program.~~  
20 The amount of subsidy for purposes of this item (4) is  
21 calculated in the same manner as unreimbursed costs are  
22 calculated for Medicaid and other means-tested government  
23 programs in the Schedule H of IRS Form 990 in effect on the  
24 effective date of this amendatory Act of the 97th General  
25 Assembly.

26 (5) Dual-eligible subsidy. The amount of subsidy

1 provided to government by treating dual-eligible  
2 Medicare/Medicaid patients. The amount of subsidy for  
3 purposes of this item (5) is calculated by multiplying the  
4 relevant hospital entity's unreimbursed costs for  
5 Medicare, calculated in the same manner as determined in  
6 the Schedule H of IRS Form 990 in effect on the effective  
7 date of this amendatory Act of the 97th General Assembly,  
8 by the relevant hospital entity's ratio of dual-eligible  
9 patients to total Medicare patients.

10 (6) Relief of the burden of government related to  
11 health care. Except to the extent otherwise taken into  
12 account in this subsection, the portion of unreimbursed  
13 costs of the relevant hospital entity attributable to  
14 providing, paying for, or subsidizing goods, activities,  
15 or services that relieve the burden of government related  
16 to health care for low-income individuals. Such activities  
17 or services shall include, but are not limited to,  
18 providing emergency, trauma, burn, neonatal, psychiatric,  
19 rehabilitation, or other special services; providing  
20 medical education; and conducting medical research or  
21 training of health care professionals. The portion of  
22 those unreimbursed costs attributable to benefiting  
23 low-income individuals shall be determined using the ratio  
24 calculated by adding the relevant hospital entity's costs  
25 attributable to charity care, Medicaid, other means-tested  
26 government programs, Medicare patients with disabilities

1 under age 65, and dual-eligible Medicare/Medicaid patients  
2 and dividing that total by the relevant hospital entity's  
3 total costs. Such costs for the numerator and denominator  
4 shall be determined by multiplying gross charges by the  
5 cost to charge ratio taken from the hospital's most  
6 recently filed Medicare cost report (CMS 2252-10  
7 Worksheet, Part I). In the case of emergency services, the  
8 ratio shall be calculated using costs (gross charges  
9 multiplied by the cost to charge ratio taken from the  
10 hospital's most recently filed Medicare cost report (CMS  
11 2252-10 Worksheet, Part I)) of patients treated in the  
12 relevant hospital entity's emergency department.

13 (7) Any other activity by the relevant hospital entity  
14 that the Department determines relieves the burden of  
15 government or addresses the health of low-income or  
16 underserved individuals.

17 (d) The hospital applicant shall include information in  
18 its exemption application establishing that it satisfies the  
19 requirements of subsection (b). For purposes of making the  
20 calculations required by subsection (b), the hospital  
21 applicant may for each year elect to use either (1) the value  
22 of the services or activities listed in subsection (e) for the  
23 hospital year or (2) the average value of those services or  
24 activities for the 3 fiscal years ending with the hospital  
25 year. If the relevant hospital entity has been in operation  
26 for less than 3 completed fiscal years, then the latter

1 calculation, if elected, shall be performed on a pro rata  
2 basis.

3 (e) For purposes of making the calculations required by  
4 this Section:

5 (1) particular services or activities eligible for  
6 consideration under any of the paragraphs (1) through (7)  
7 of subsection (c) may not be counted under more than one of  
8 those paragraphs; and

9 (2) the amount of unreimbursed costs and the amount of  
10 subsidy shall not be reduced by restricted or unrestricted  
11 payments received by the relevant hospital entity as  
12 contributions deductible under Section 170(a) of the  
13 Internal Revenue Code.

14 (f) (Blank).

15 (g) Estimation of Exempt Property Tax Liability. The  
16 estimated property tax liability used for the determination in  
17 subsection (b) shall be calculated as follows:

18 (1) "Estimated property tax liability" means the  
19 estimated dollar amount of property tax that would be  
20 owed, with respect to the exempt portion of each of the  
21 relevant hospital entity's properties that are already  
22 fully or partially exempt, or for which an exemption in  
23 whole or in part is currently being sought, and then  
24 aggregated as applicable, as if the exempt portion of  
25 those properties were subject to tax, calculated with  
26 respect to each such property by multiplying:

1 (A) the lesser of (i) the actual assessed value,  
2 if any, of the portion of the property for which an  
3 exemption is sought or (ii) an estimated assessed  
4 value of the exempt portion of such property as  
5 determined in item (2) of this subsection (g), by

6 (B) the applicable State equalization rate  
7 (yielding the equalized assessed value), by

8 (C) the applicable tax rate.

9 (2) The estimated assessed value of the exempt portion  
10 of the property equals the sum of (i) the estimated fair  
11 market value of buildings on the property, as determined  
12 in accordance with subparagraphs (A) and (B) of this item  
13 (2), multiplied by the applicable assessment factor, and  
14 (ii) the estimated assessed value of the land portion of  
15 the property, as determined in accordance with  
16 subparagraph (C).

17 (A) The "estimated fair market value of buildings  
18 on the property" means the replacement value of any  
19 exempt portion of buildings on the property, minus  
20 depreciation, determined utilizing the cost  
21 replacement method whereby the exempt square footage  
22 of all such buildings is multiplied by the replacement  
23 cost per square foot for Class A Average building  
24 found in the most recent edition of the Marshall &  
25 Swift Valuation Services Manual, adjusted by any  
26 appropriate current cost and local multipliers.

1 (B) Depreciation, for purposes of calculating the  
2 estimated fair market value of buildings on the  
3 property, is applied by utilizing a weighted mean life  
4 for the buildings based on original construction and  
5 assuming a 40-year life for hospital buildings and the  
6 applicable life for other types of buildings as  
7 specified in the American Hospital Association  
8 publication "Estimated Useful Lives of Depreciable  
9 Hospital Assets". In the case of hospital buildings,  
10 the remaining life is divided by 40 and this ratio is  
11 multiplied by the replacement cost of the buildings to  
12 obtain an estimated fair market value of buildings. If  
13 a hospital building is older than 35 years, a  
14 remaining life of 5 years for residual value is  
15 assumed; and if a building is less than 8 years old, a  
16 remaining life of 32 years is assumed.

17 (C) The estimated assessed value of the land  
18 portion of the property shall be determined by  
19 multiplying (i) the per square foot average of the  
20 assessed values of three parcels of land (not  
21 including farm land, and excluding the assessed value  
22 of the improvements thereon) reasonably comparable to  
23 the property, by (ii) the number of square feet  
24 comprising the exempt portion of the property's land  
25 square footage.

26 (3) The assessment factor, State equalization rate,

1 and tax rate (including any special factors such as  
2 Enterprise Zones) used in calculating the estimated  
3 property tax liability shall be for the most recent year  
4 that is publicly available from the applicable chief  
5 county assessment officer or officers at least 90 days  
6 before the end of the hospital year.

7 (4) The method utilized to calculate estimated  
8 property tax liability for purposes of this Section 15-86  
9 shall not be utilized for the actual valuation,  
10 assessment, or taxation of property pursuant to the  
11 Property Tax Code.

12 (h) For the purpose of this Section, the following terms  
13 shall have the meanings set forth below:

14 (1) "Hospital" means any institution, place, building,  
15 buildings on a campus, or other health care facility  
16 located in Illinois that is licensed under the Hospital  
17 Licensing Act and has a hospital owner.

18 (2) "Hospital owner" means a not-for-profit  
19 corporation that is the titleholder of a hospital, or the  
20 owner of the beneficial interest in an Illinois land trust  
21 that is the titleholder of a hospital.

22 (3) "Hospital affiliate" means any corporation,  
23 partnership, limited partnership, joint venture, limited  
24 liability company, association or other organization,  
25 other than a hospital owner, that directly or indirectly  
26 controls, is controlled by, or is under common control



1 with one or more hospital owners and that supports, is  
2 supported by, or acts in furtherance of the exempt health  
3 care purposes of at least one of those hospital owners'  
4 hospitals.

5 (4) "Hospital system" means a hospital and one or more  
6 other hospitals or hospital affiliates related by common  
7 control or ownership.

8 (5) "Control" relating to hospital owners, hospital  
9 affiliates, or hospital systems means possession, direct  
10 or indirect, of the power to direct or cause the direction  
11 of the management and policies of the entity, whether  
12 through ownership of assets, membership interest, other  
13 voting or governance rights, by contract or otherwise.

14 (6) "Hospital applicant" means a hospital owner or  
15 hospital affiliate that files an application for an  
16 exemption or renewal of exemption under this Section.

17 (7) "Relevant hospital entity" means (A) the hospital  
18 owner, in the case of a hospital applicant that is a  
19 hospital owner, and (B) at the election of a hospital  
20 applicant that is a hospital affiliate, either (i) the  
21 hospital affiliate or (ii) the hospital system to which  
22 the hospital applicant belongs, including any hospitals or  
23 hospital affiliates that are related by common control or  
24 ownership.

25 (8) "Subject property" means property used for the  
26 calculation under subsection (b) of this Section.

1           (9) "Hospital year" means the fiscal year of the  
2           relevant hospital entity, or the fiscal year of one of the  
3           hospital owners in the hospital system if the relevant  
4           hospital entity is a hospital system with members with  
5           different fiscal years, that ends in the year for which  
6           the exemption is sought.

7           (i) It is the intent of the General Assembly that any  
8           exemptions taken, granted, or renewed under this Section prior  
9           to the effective date of this amendatory Act of the 100th  
10          General Assembly are hereby validated.

11          (Source: P.A. 99-143, eff. 7-27-15; 100-1181, eff. 3-8-19.)

12          Section 30. The Property Tax Code is amended by changing  
13          Section 15-86 as follows:

14                 (35 ILCS 200/15-86)

15                 Sec. 15-86. Exemptions related to access to hospital and  
16                 health care services by low-income and underserved  
17                 individuals.

18                 (a) The General Assembly finds:

19                         (1) Despite the Supreme Court's decision in *Provena*  
20                         *Covenant Medical Center v. Dept. of Revenue*, 236 Ill.2d  
21                         368, there is considerable uncertainty surrounding the  
22                         test for charitable property tax exemption, especially  
23                         regarding the application of a quantitative or monetary  
24                         threshold. In *Provena*, the Department stated that the

1 primary basis for its decision was the hospital's  
2 inadequate amount of charitable activity, but the  
3 Department has not articulated what constitutes an  
4 adequate amount of charitable activity. After *Provena*, the  
5 Department denied property tax exemption applications of 3  
6 more hospitals, and, on the effective date of this  
7 amendatory Act of the 97th General Assembly, at least 20  
8 other hospitals are awaiting rulings on applications for  
9 property tax exemption.

10 (2) In *Provena*, two Illinois Supreme Court justices  
11 opined that "setting a monetary or quantum standard is a  
12 complex decision which should be left to our legislature,  
13 should it so choose". The Appellate Court in *Provena*  
14 stated: "The language we use in the State of Illinois to  
15 determine whether real property is used for a charitable  
16 purpose has its genesis in our 1870 Constitution. It is  
17 obvious that such language may be difficult to apply to  
18 the modern face of our nation's health care delivery  
19 systems". The court noted the many significant changes in  
20 the health care system since that time, but concluded that  
21 taking these changes into account is a matter of public  
22 policy, and "it is the legislature's job, not ours, to  
23 make public policy".

24 (3) It is essential to ensure that tax exemption law  
25 relating to hospitals accounts for the complexities of the  
26 modern health care delivery system. Health care is moving

1 beyond the walls of the hospital. In addition to treating  
2 individual patients, hospitals are assuming responsibility  
3 for improving the health status of communities and  
4 populations. Low-income and underserved communities  
5 benefit disproportionately by these activities.

6 (4) The Supreme Court has explained that: "the  
7 fundamental ground upon which all exemptions in favor of  
8 charitable institutions are based is the benefit conferred  
9 upon the public by them, and a consequent relief, to some  
10 extent, of the burden upon the state to care for and  
11 advance the interests of its citizens". Hospitals relieve  
12 the burden of government in many ways, but most  
13 significantly through their participation in and  
14 substantial financial subsidization of the Illinois  
15 Medicaid program, which could not operate without the  
16 participation and partnership of Illinois hospitals.

17 (5) Working with the Illinois hospital community and  
18 other interested parties, the General Assembly has  
19 developed a comprehensive combination of related  
20 legislation that addresses hospital property tax  
21 exemption, significantly increases access to free health  
22 care for indigent persons, and strengthens the Medical  
23 Assistance program. It is the intent of the General  
24 Assembly to establish a new category of ownership for  
25 charitable property tax exemption to be applied to  
26 not-for-profit hospitals and hospital affiliates in lieu

1 of the existing ownership category of "institutions of  
2 public charity". It is also the intent of the General  
3 Assembly to establish quantifiable standards for the  
4 issuance of charitable exemptions for such property. It is  
5 not the intent of the General Assembly to declare any  
6 property exempt ipso facto, but rather to establish  
7 criteria to be applied to the facts on a case-by-case  
8 basis.

9 (b) For the purpose of this Section and Section 15-10, the  
10 following terms shall have the meanings set forth below:

11 (1) "Hospital" means any institution, place, building,  
12 buildings on a campus, or other health care facility  
13 located in Illinois that is licensed under the Hospital  
14 Licensing Act and has a hospital owner.

15 (2) "Hospital owner" means a not-for-profit  
16 corporation that is the titleholder of a hospital, or the  
17 owner of the beneficial interest in an Illinois land trust  
18 that is the titleholder of a hospital.

19 (3) "Hospital affiliate" means any corporation,  
20 partnership, limited partnership, joint venture, limited  
21 liability company, association or other organization,  
22 other than a hospital owner, that directly or indirectly  
23 controls, is controlled by, or is under common control  
24 with one or more hospital owners and that supports, is  
25 supported by, or acts in furtherance of the exempt health  
26 care purposes of at least one of those hospital owners'

1 hospitals.

2 (4) "Hospital system" means a hospital and one or more  
3 other hospitals or hospital affiliates related by common  
4 control or ownership.

5 (5) "Control" relating to hospital owners, hospital  
6 affiliates, or hospital systems means possession, direct  
7 or indirect, of the power to direct or cause the direction  
8 of the management and policies of the entity, whether  
9 through ownership of assets, membership interest, other  
10 voting or governance rights, by contract or otherwise.

11 (6) "Hospital applicant" means a hospital owner or  
12 hospital affiliate that files an application for a  
13 property tax exemption pursuant to Section 15-5 and this  
14 Section.

15 (7) "Relevant hospital entity" means (A) the hospital  
16 owner, in the case of a hospital applicant that is a  
17 hospital owner, and (B) at the election of a hospital  
18 applicant that is a hospital affiliate, either (i) the  
19 hospital affiliate or (ii) the hospital system to which  
20 the hospital applicant belongs, including any hospitals or  
21 hospital affiliates that are related by common control or  
22 ownership.

23 (8) "Subject property" means property for which a  
24 hospital applicant files an application for an exemption  
25 pursuant to Section 15-5 and this Section.

26 (9) "Hospital year" means the fiscal year of the

1 relevant hospital entity, or the fiscal year of one of the  
2 hospital owners in the hospital system if the relevant  
3 hospital entity is a hospital system with members with  
4 different fiscal years, that ends in the year for which  
5 the exemption is sought.

6 (c) A hospital applicant satisfies the conditions for an  
7 exemption under this Section with respect to the subject  
8 property, and shall be issued a charitable exemption for that  
9 property, if the value of services or activities listed in  
10 subsection (e) for the hospital year equals or exceeds the  
11 relevant hospital entity's estimated property tax liability,  
12 as determined under subsection (g), for the year for which  
13 exemption is sought. For purposes of making the calculations  
14 required by this subsection (c), if the relevant hospital  
15 entity is a hospital owner that owns more than one hospital,  
16 the value of the services or activities listed in subsection  
17 (e) shall be calculated on the basis of only those services and  
18 activities relating to the hospital that includes the subject  
19 property, and the relevant hospital entity's estimated  
20 property tax liability shall be calculated only with respect  
21 to the properties comprising that hospital. In the case of a  
22 multi-state hospital system or hospital affiliate, the value  
23 of the services or activities listed in subsection (e) shall  
24 be calculated on the basis of only those services and  
25 activities that occur in Illinois and the relevant hospital  
26 entity's estimated property tax liability shall be calculated

1 only with respect to its property located in Illinois.

2 Notwithstanding any other provisions of this Act, any  
3 parcel or portion thereof, that is owned by a for-profit  
4 entity whether part of the hospital system or not, or that is  
5 leased, licensed or operated by a for-profit entity regardless  
6 of whether healthcare services are provided on that parcel  
7 shall not qualify for exemption. If a parcel has both exempt  
8 and non-exempt uses, an exemption may be granted for the  
9 qualifying portion of that parcel. In the case of parking lots  
10 and common areas serving both exempt and non-exempt uses those  
11 parcels or portions thereof may qualify for an exemption in  
12 proportion to the amount of qualifying use.

13 (d) The hospital applicant shall include information in  
14 its exemption application establishing that it satisfies the  
15 requirements of subsection (c). For purposes of making the  
16 calculations required by subsection (c), the hospital  
17 applicant may for each year elect to use either (1) the value  
18 of the services or activities listed in subsection (e) for the  
19 hospital year or (2) the average value of those services or  
20 activities for the 3 fiscal years ending with the hospital  
21 year. If the relevant hospital entity has been in operation  
22 for less than 3 completed fiscal years, then the latter  
23 calculation, if elected, shall be performed on a pro rata  
24 basis.

25 (e) Services that address the health care needs of  
26 low-income or underserved individuals or relieve the burden of



1 government with regard to health care services. The following  
2 services and activities shall be considered for purposes of  
3 making the calculations required by subsection (c):

4 (1) Charity care. Free or discounted services provided  
5 pursuant to the relevant hospital entity's financial  
6 assistance policy, measured at cost, including discounts  
7 provided under the Hospital Uninsured Patient Discount  
8 Act.

9 (2) Health services to low-income and underserved  
10 individuals. Other unreimbursed costs of the relevant  
11 hospital entity for providing without charge, paying for,  
12 or subsidizing goods, activities, or services for the  
13 purpose of addressing the health of low-income or  
14 underserved individuals. Those activities or services may  
15 include, but are not limited to: financial or in-kind  
16 support to affiliated or unaffiliated hospitals, hospital  
17 affiliates, community clinics, or programs that treat  
18 low-income or underserved individuals; paying for or  
19 subsidizing health care professionals who care for  
20 low-income or underserved individuals; providing or  
21 subsidizing outreach or educational services to low-income  
22 or underserved individuals for disease management and  
23 prevention; free or subsidized goods, supplies, or  
24 services needed by low-income or underserved individuals  
25 because of their medical condition; and prenatal or  
26 childbirth outreach to low-income or underserved persons.

1           (3) Subsidy of State or local governments. Direct or  
2 indirect financial or in-kind subsidies of State or local  
3 governments by the relevant hospital entity that pay for  
4 or subsidize activities or programs related to health care  
5 for low-income or underserved individuals.

6           (4) Support for State health care programs for  
7 low-income individuals. At the election of the hospital  
8 applicant for each applicable year, either (A) 10% of  
9 payments to the relevant hospital entity and any hospital  
10 affiliate designated by the relevant hospital entity  
11 (provided that such hospital affiliate's operations  
12 provide financial or operational support for or receive  
13 financial or operational support from the relevant  
14 hospital entity) under Medicaid or other means-tested  
15 programs, including, but not limited to, General  
16 Assistance, ~~the Covering ALL KIDS Health Insurance Act,~~  
17 ~~and the State Children's Health Insurance Program~~ or (B)  
18 the amount of subsidy provided by the relevant hospital  
19 entity and any hospital affiliate designated by the  
20 relevant hospital entity (provided that such hospital  
21 affiliate's operations provide financial or operational  
22 support for or receive financial or operational support  
23 from the relevant hospital entity) to State or local  
24 government in treating Medicaid recipients and recipients  
25 of means-tested programs, including but not limited to  
26 General Assistance, ~~the Covering ALL KIDS Health Insurance~~

1 ~~Act, and the State Children's Health Insurance Program.~~

2 The amount of subsidy for purposes of this item (4) is  
3 calculated in the same manner as unreimbursed costs are  
4 calculated for Medicaid and other means-tested government  
5 programs in the Schedule H of IRS Form 990 in effect on the  
6 effective date of this amendatory Act of the 97th General  
7 Assembly; provided, however, that in any event  
8 unreimbursed costs shall be net of fee-for-services  
9 payments, payments pursuant to an assessment, quarterly  
10 payments, and all other payments included on the schedule  
11 H of the IRS form 990.

12 (5) Dual-eligible subsidy. The amount of subsidy  
13 provided to government by treating dual-eligible  
14 Medicare/Medicaid patients. The amount of subsidy for  
15 purposes of this item (5) is calculated by multiplying the  
16 relevant hospital entity's unreimbursed costs for  
17 Medicare, calculated in the same manner as determined in  
18 the Schedule H of IRS Form 990 in effect on the effective  
19 date of this amendatory Act of the 97th General Assembly,  
20 by the relevant hospital entity's ratio of dual-eligible  
21 patients to total Medicare patients.

22 (6) Relief of the burden of government related to  
23 health care of low-income individuals. Except to the  
24 extent otherwise taken into account in this subsection,  
25 the portion of unreimbursed costs of the relevant hospital  
26 entity attributable to providing, paying for, or

1 subsidizing goods, activities, or services that relieve  
2 the burden of government related to health care for  
3 low-income individuals. Such activities or services shall  
4 include, but are not limited to, providing emergency,  
5 trauma, burn, neonatal, psychiatric, rehabilitation, or  
6 other special services; providing medical education; and  
7 conducting medical research or training of health care  
8 professionals. The portion of those unreimbursed costs  
9 attributable to benefiting low-income individuals shall be  
10 determined using the ratio calculated by adding the  
11 relevant hospital entity's costs attributable to charity  
12 care, Medicaid, other means-tested government programs,  
13 Medicare patients with disabilities under age 65, and  
14 dual-eligible Medicare/Medicaid patients and dividing that  
15 total by the relevant hospital entity's total costs. Such  
16 costs for the numerator and denominator shall be  
17 determined by multiplying gross charges by the cost to  
18 charge ratio taken from the hospitals' most recently filed  
19 Medicare cost report (CMS 2252-10 Worksheet C, Part I). In  
20 the case of emergency services, the ratio shall be  
21 calculated using costs (gross charges multiplied by the  
22 cost to charge ratio taken from the hospitals' most  
23 recently filed Medicare cost report (CMS 2252-10 Worksheet  
24 C, Part I)) of patients treated in the relevant hospital  
25 entity's emergency department.

26 (7) Any other activity by the relevant hospital entity

1           that the Department determines relieves the burden of  
2           government or addresses the health of low-income or  
3           underserved individuals.

4           (f) For purposes of making the calculations required by  
5           subsections (c) and (e):

6                 (1) particular services or activities eligible for  
7                 consideration under any of the paragraphs (1) through (7)  
8                 of subsection (e) may not be counted under more than one of  
9                 those paragraphs; and

10                (2) the amount of unreimbursed costs and the amount of  
11                subsidy shall not be reduced by restricted or unrestricted  
12                payments received by the relevant hospital entity as  
13                contributions deductible under Section 170(a) of the  
14                Internal Revenue Code.

15           (g) Estimation of Exempt Property Tax Liability. The  
16           estimated property tax liability used for the determination in  
17           subsection (c) shall be calculated as follows:

18                 (1) "Estimated property tax liability" means the  
19                 estimated dollar amount of property tax that would be  
20                 owed, with respect to the exempt portion of each of the  
21                 relevant hospital entity's properties that are already  
22                 fully or partially exempt, or for which an exemption in  
23                 whole or in part is currently being sought, and then  
24                 aggregated as applicable, as if the exempt portion of  
25                 those properties were subject to tax, calculated with  
26                 respect to each such property by multiplying:

1           (A) the lesser of (i) the actual assessed value,  
2           if any, of the portion of the property for which an  
3           exemption is sought or (ii) an estimated assessed  
4           value of the exempt portion of such property as  
5           determined in item (2) of this subsection (g), by:

6           (B) the applicable State equalization rate  
7           (yielding the equalized assessed value), by

8           (C) the applicable tax rate.

9           (2) The estimated assessed value of the exempt portion  
10          of the property equals the sum of (i) the estimated fair  
11          market value of buildings on the property, as determined  
12          in accordance with subparagraphs (A) and (B) of this item  
13          (2), multiplied by the applicable assessment factor, and  
14          (ii) the estimated assessed value of the land portion of  
15          the property, as determined in accordance with  
16          subparagraph (C).

17          (A) The "estimated fair market value of buildings  
18          on the property" means the replacement value of any  
19          exempt portion of buildings on the property, minus  
20          depreciation, determined utilizing the cost  
21          replacement method whereby the exempt square footage  
22          of all such buildings is multiplied by the replacement  
23          cost per square foot for Class A Average building  
24          found in the most recent edition of the Marshall &  
25          Swift Valuation Services Manual, adjusted by any  
26          appropriate current cost and local multipliers.

1 (B) Depreciation, for purposes of calculating the  
2 estimated fair market value of buildings on the  
3 property, is applied by utilizing a weighted mean life  
4 for the buildings based on original construction and  
5 assuming a 40-year life for hospital buildings and the  
6 applicable life for other types of buildings as  
7 specified in the American Hospital Association  
8 publication "Estimated Useful Lives of Depreciable  
9 Hospital Assets". In the case of hospital buildings,  
10 the remaining life is divided by 40 and this ratio is  
11 multiplied by the replacement cost of the buildings to  
12 obtain an estimated fair market value of buildings. If  
13 a hospital building is older than 35 years, a  
14 remaining life of 5 years for residual value is  
15 assumed; and if a building is less than 8 years old, a  
16 remaining life of 32 years is assumed.

17 (C) The estimated assessed value of the land  
18 portion of the property shall be determined by  
19 multiplying (i) the per square foot average of the  
20 assessed values of three parcels of land (not  
21 including farm land, and excluding the assessed value  
22 of the improvements thereon) reasonably comparable to  
23 the property, by (ii) the number of square feet  
24 comprising the exempt portion of the property's land  
25 square footage.

26 (3) The assessment factor, State equalization rate,

1 and tax rate (including any special factors such as  
2 Enterprise Zones) used in calculating the estimated  
3 property tax liability shall be for the most recent year  
4 that is publicly available from the applicable chief  
5 county assessment officer or officers at least 90 days  
6 before the end of the hospital year.

7 (4) The method utilized to calculate estimated  
8 property tax liability for purposes of this Section 15-86  
9 shall not be utilized for the actual valuation,  
10 assessment, or taxation of property pursuant to the  
11 Property Tax Code.

12 (h) Application. Each hospital applicant applying for a  
13 property tax exemption pursuant to Section 15-5 and this  
14 Section shall use an application form provided by the  
15 Department. The application form shall specify the records  
16 required in support of the application and those records shall  
17 be submitted to the Department with the application form. Each  
18 application or affidavit shall contain a verification by the  
19 Chief Executive Officer of the hospital applicant under oath  
20 or affirmation stating that each statement in the application  
21 or affidavit and each document submitted with the application  
22 or affidavit are true and correct. The records submitted with  
23 the application pursuant to this Section shall include an  
24 exhibit prepared by the relevant hospital entity showing (A)  
25 the value of the relevant hospital entity's services and  
26 activities, if any, under paragraphs (1) through (7) of



1 subsection (e) of this Section stated separately for each  
2 paragraph, and (B) the value relating to the relevant hospital  
3 entity's estimated property tax liability under subsections  
4 (g)(1)(A), (B), and (C), subsections (g)(2)(A), (B), and (C),  
5 and subsection (g)(3) of this Section stated separately for  
6 each item. Such exhibit will be made available to the public by  
7 the chief county assessment officer. Nothing in this Section  
8 shall be construed as limiting the Attorney General's  
9 authority under the Illinois False Claims Act.

10 (i) Nothing in this Section shall be construed to limit  
11 the ability of otherwise eligible hospitals, hospital owners,  
12 hospital affiliates, or hospital systems to obtain or maintain  
13 property tax exemptions pursuant to a provision of the  
14 Property Tax Code other than this Section.

15 (Source: P.A. 99-143, eff. 7-27-15.)

16 Section 35. The Illinois Pension Code is amended by  
17 changing Section 24-102 as follows:

18 (40 ILCS 5/24-102) (from Ch. 108 1/2, par. 24-102)

19 Sec. 24-102. As used in this Article, "employee" means any  
20 person, including a person elected, appointed or under  
21 contract, receiving compensation from the State or a unit of  
22 local government or school district for personal services  
23 rendered, including salaried persons. A health care provider  
24 who elects to participate in the State Employees Deferred

1 Compensation Plan established under Section 24-104 of this  
2 Code shall, for purposes of that participation, be deemed an  
3 "employee" as defined in this Section.

4 As used in this Article, "health care provider" means a  
5 dentist, physician, optometrist, pharmacist, or podiatric  
6 physician that participates and receives compensation as a  
7 provider under the Illinois Public Aid Code, ~~the Children's~~  
8 ~~Health Insurance Act, or the Covering ALL KIDS Health~~  
9 ~~Insurance Act.~~

10 As used in this Article, "compensation" includes  
11 compensation received in a lump sum for accumulated unused  
12 vacation, personal leave or sick leave, with the exception of  
13 health care providers. "Compensation" with respect to health  
14 care providers is defined under the Illinois Public Aid Code, ~~7~~  
15 ~~the Children's Health Insurance Act, or the Covering ALL KIDS~~  
16 ~~Health Insurance Act.~~

17 Where applicable, in no event shall the total of the  
18 amount of deferred compensation of an employee set aside in  
19 relation to a particular year under the Illinois State  
20 Employees Deferred Compensation Plan and the employee's  
21 nondeferred compensation for that year exceed the total annual  
22 salary or compensation under the existing salary schedule or  
23 classification plan applicable to such employee in such year;  
24 except that any compensation received in a lump sum for  
25 accumulated unused vacation, personal leave or sick leave  
26 shall not be included in the calculation of such totals.

1 (Source: P.A. 98-214, eff. 8-9-13.)

2 Section 40. The Loan Repayment Assistance for Dentists Act  
3 is amended by changing Sections 10, 25, and 30 as follows:

4 (110 ILCS 948/10)

5 Sec. 10. Definitions. In this Act, unless the context  
6 otherwise requires:

7 "Dental hygienist" means a person who holds a license  
8 under the Illinois Dental Practice Act to perform dental  
9 services as authorized by Section 18 of the Illinois Dental  
10 Practice Act.

11 "Dental payments" means compensation provided to dentists  
12 and dental specialists for services rendered under Article V  
13 of the Illinois Public Aid Code, ~~the Covering ALL KIDS Health~~  
14 ~~Insurance Act, or the Children's Health Insurance Program Act.~~

15 "Dental specialist" means a person who has received a  
16 license as a dentist in this State and who is trained and  
17 qualified to practice in one or more of the following  
18 specialties of dentistry: endodontics, oral and maxillofacial  
19 surgery, orthodontics, pedodontics, periodontics, and  
20 prosthodontics.

21 "Dentist" means a person who has received a general  
22 license pursuant to paragraph (a) of Section 11 of the  
23 Illinois Dental Practice Act, who may perform any intraoral  
24 and extraoral procedure required in the practice of dentistry,

1 and to whom is reserved the responsibilities specified in  
2 Section 17 of the Illinois Dental Practice Act.

3 "Department" means the Department of Public Health.

4 "Designated shortage area" means a medically underserved  
5 area or health manpower shortage area as defined by the United  
6 States Department of Health and Human Services or as otherwise  
7 designated by the Department of Public Health.

8 "Educational loans" means higher education student loans  
9 that a person has incurred in attending a registered  
10 professional dental education program.

11 "Program" means the educational loan repayment assistance  
12 program for dentists and dental specialists or dental  
13 hygienists established by the Department under this Act.

14 (Source: P.A. 95-297, eff. 8-20-07; 96-757, eff. 8-25-09.)

15 (110 ILCS 948/25)

16 Sec. 25. Eligibility. To be eligible for assistance under  
17 the program, an applicant must meet all of the following  
18 qualifications:

19 (1) He or she must be a citizen or permanent resident  
20 of the United States.

21 (2) He or she must be a resident of this State.

22 (3) He or she must be practicing full time in this  
23 State as a dentist, dental specialist, or dental  
24 hygienist.

25 (4) He or she must currently be repaying educational

1 loans.

2 (5) He or she must accept dental payments as defined  
3 in this Act.

4 (6) He or she must practice or commit to practice full  
5 time in this State in a designated shortage area.

6 (7) He or she must allocate at least 20% of all patient  
7 appointments to patients covered by Article V of the  
8 Illinois Public Aid Code, ~~the Covering ALL KIDS Health~~  
9 ~~Insurance Act, or the Children's Health Insurance Program~~  
10 ~~Act.~~

11 (Source: P.A. 95-297, eff. 8-20-07; 96-757, eff. 8-25-09.)

12 (110 ILCS 948/30)

13 Sec. 30. The award of grants.

14 (a) Under the program, for each year that a qualified  
15 applicant practices full time in this State in a designated  
16 shortage area as a dentist or dental specialist, the  
17 Department shall, subject to appropriation, award a grant to  
18 that person in an amount equal to the amount in educational  
19 loans that the person must repay that year. However, the total  
20 amount in grants that a person may be awarded under the program  
21 must not exceed \$25,000 per year for a 4-year period.

22 The grant award for a dental hygienist shall be set by rule  
23 of the Department.

24 (b) The Department shall require recipients to use the  
25 grants to pay off their educational loans.

1 (c) The initial grant awarded to a dentist or dental  
2 specialist under this Act shall be for a 2-year period. Based  
3 on the successful completion of the initial 2-year grant, the  
4 grantees may be awarded up to 2 subsequent one-year grants.  
5 Grantees are eligible to receive grant funds for no more than a  
6 4-year period. Previous grant recipients shall be given  
7 priority for years 3 and 4 grant funding, provided that the  
8 grantee continues to meet the eligibility requirements set  
9 forth in Section 25 of this Act. Grantees shall practice full  
10 time in a designated shortage area for the period of each grant  
11 awarded.

12 The grant award for a dental hygienist shall be for a  
13 maximum of 2 years.

14 (d) Successful applicants shall be eligible for a grant  
15 award upon execution of the grant agreement and shall then  
16 begin to receive grant award payments on a quarterly basis.

17 (e) The Department shall award grants to otherwise  
18 eligible dental applicants by using the following criteria:

19 (1) Dental specialist willing to practice in any  
20 designated shortage area.

21 (2) Dentist willing to practice in a designated  
22 shortage area with the highest Health Professional  
23 Shortage Area (HPSA) score.

24 (3) Dentist willing to practice in a designated  
25 shortage area with the highest HPSA score and agreeing to  
26 allocate the highest percentage of patient appointments to

1 those that are covered by Article V of the Illinois Public  
2 Aid Code, ~~the Covering ALL KIDS Health Insurance Act, or~~  
3 ~~the Children's Health Insurance Program Act.~~

4 (Source: P.A. 95-297, eff. 8-20-07; 96-757, eff. 8-25-09.)

5 Section 45. The Illinois Insurance Code is amended by  
6 changing Section 352 as follows:

7 (215 ILCS 5/352) (from Ch. 73, par. 964)

8 Sec. 352. Scope of Article.

9 (a) Except as provided in subsections (b), (c), (d), and  
10 (e), this Article shall apply to all companies transacting in  
11 this State the kinds of business enumerated in clause (b) of  
12 Class 1 and clause (a) of Class 2 of Section 4. Nothing in this  
13 Article shall apply to, or in any way affect policies or  
14 contracts described in clause (a) of Class 1 of Section 4;  
15 however, this Article shall apply to policies and contracts  
16 which contain benefits providing reimbursement for the  
17 expenses of long term health care which are certified or  
18 ordered by a physician including but not limited to  
19 professional nursing care, custodial nursing care, and  
20 non-nursing custodial care provided in a nursing home or at a  
21 residence of the insured.

22 (b) (Blank).

23 (c) A policy issued and delivered in this State that  
24 provides coverage under that policy for certificate holders

1 who are neither residents of nor employed in this State does  
2 not need to provide to those nonresident certificate holders  
3 who are not employed in this State the coverages or services  
4 mandated by this Article.

5 (d) Stop-loss insurance is exempt from all Sections of  
6 this Article, except this Section and Sections 353a, 354,  
7 357.30, and 370. For purposes of this exemption, stop-loss  
8 insurance is further defined as follows:

9 (1) The policy must be issued to and insure an  
10 employer, trustee, or other sponsor of the plan, or the  
11 plan itself, but not employees, members, or participants.

12 (2) Payments by the insurer must be made to the  
13 employer, trustee, or other sponsors of the plan, or the  
14 plan itself, but not to the employees, members,  
15 participants, or health care providers.

16 (e) A policy issued or delivered in this State to the  
17 Department of Healthcare and Family Services (formerly  
18 Illinois Department of Public Aid) and providing coverage,  
19 under clause (b) of Class 1 or clause (a) of Class 2 as  
20 described in Section 4, to persons who are enrolled under  
21 Article V of the Illinois Public Aid Code ~~or under the~~  
22 ~~Children's Health Insurance Program Act~~ is exempt from all  
23 restrictions, limitations, standards, rules, or regulations  
24 respecting benefits imposed by or under authority of this  
25 Code, except those specified by subsection (1) of Section 143,  
26 Section 370c, and Section 370c.1. Nothing in this subsection,



1 however, affects the total medical services available to  
2 persons eligible for medical assistance under the Illinois  
3 Public Aid Code.

4 (f) An in-office membership care agreement provided under  
5 the In-Office Membership Care Act is not insurance for the  
6 purposes of this Code.

7 (Source: P.A. 101-190, eff. 8-2-19.)

8 Section 50. The Health Maintenance Organization Act is  
9 amended by changing Section 1-2 as follows:

10 (215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

11 Sec. 1-2. Definitions. As used in this Act, unless the  
12 context otherwise requires, the following terms shall have the  
13 meanings ascribed to them:

14 (1) "Advertisement" means any printed or published  
15 material, audiovisual material and descriptive literature of  
16 the health care plan used in direct mail, newspapers,  
17 magazines, radio scripts, television scripts, billboards and  
18 similar displays; and any descriptive literature or sales aids  
19 of all kinds disseminated by a representative of the health  
20 care plan for presentation to the public including, but not  
21 limited to, circulars, leaflets, booklets, depictions,  
22 illustrations, form letters and prepared sales presentations.

23 (2) "Director" means the Director of Insurance.

24 (3) "Basic health care services" means emergency care, and

1 inpatient hospital and physician care, outpatient medical  
2 services, mental health services and care for alcohol and drug  
3 abuse, including any reasonable deductibles and co-payments,  
4 all of which are subject to the limitations described in  
5 Section 4-20 of this Act and as determined by the Director  
6 pursuant to rule.

7 (4) "Enrollee" means an individual who has been enrolled  
8 in a health care plan.

9 (5) "Evidence of coverage" means any certificate,  
10 agreement, or contract issued to an enrollee setting out the  
11 coverage to which he is entitled in exchange for a per capita  
12 prepaid sum.

13 (6) "Group contract" means a contract for health care  
14 services which by its terms limits eligibility to members of a  
15 specified group.

16 (7) "Health care plan" means any arrangement whereby any  
17 organization undertakes to provide or arrange for and pay for  
18 or reimburse the cost of basic health care services, excluding  
19 any reasonable deductibles and copayments, from providers  
20 selected by the Health Maintenance Organization and such  
21 arrangement consists of arranging for or the provision of such  
22 health care services, as distinguished from mere  
23 indemnification against the cost of such services, except as  
24 otherwise authorized by Section 2-3 of this Act, on a per  
25 capita prepaid basis, through insurance or otherwise. A  
26 "health care plan" also includes any arrangement whereby an

1 organization undertakes to provide or arrange for or pay for  
2 or reimburse the cost of any health care service for persons  
3 who are enrolled under Article V of the Illinois Public Aid  
4 Code ~~or under the Children's Health Insurance Program Act~~  
5 through providers selected by the organization and the  
6 arrangement consists of making provision for the delivery of  
7 health care services, as distinguished from mere  
8 indemnification. A "health care plan" also includes any  
9 arrangement pursuant to Section 4-17. Nothing in this  
10 definition, however, affects the total medical services  
11 available to persons eligible for medical assistance under the  
12 Illinois Public Aid Code.

13 (8) "Health care services" means any services included in  
14 the furnishing to any individual of medical or dental care, or  
15 the hospitalization or incident to the furnishing of such care  
16 or hospitalization as well as the furnishing to any person of  
17 any and all other services for the purpose of preventing,  
18 alleviating, curing or healing human illness or injury.

19 (9) "Health Maintenance Organization" means any  
20 organization formed under the laws of this or another state to  
21 provide or arrange for one or more health care plans under a  
22 system which causes any part of the risk of health care  
23 delivery to be borne by the organization or its providers.

24 (10) "Net worth" means admitted assets, as defined in  
25 Section 1-3 of this Act, minus liabilities.

26 (11) "Organization" means any insurance company, a

1 nonprofit corporation authorized under the Dental Service Plan  
2 Act or the Voluntary Health Services Plans Act, or a  
3 corporation organized under the laws of this or another state  
4 for the purpose of operating one or more health care plans and  
5 doing no business other than that of a Health Maintenance  
6 Organization or an insurance company. "Organization" shall  
7 also mean the University of Illinois Hospital as defined in  
8 the University of Illinois Hospital Act or a unit of local  
9 government health system operating within a county with a  
10 population of 3,000,000 or more.

11 (12) "Provider" means any physician, hospital facility,  
12 facility licensed under the Nursing Home Care Act, or facility  
13 or long-term care facility as those terms are defined in the  
14 Nursing Home Care Act or other person which is licensed or  
15 otherwise authorized to furnish health care services and also  
16 includes any other entity that arranges for the delivery or  
17 furnishing of health care service.

18 (13) "Producer" means a person directly or indirectly  
19 associated with a health care plan who engages in solicitation  
20 or enrollment.

21 (14) "Per capita prepaid" means a basis of prepayment by  
22 which a fixed amount of money is prepaid per individual or any  
23 other enrollment unit to the Health Maintenance Organization  
24 or for health care services which are provided during a  
25 definite time period regardless of the frequency or extent of  
26 the services rendered by the Health Maintenance Organization,

1 except for copayments and deductibles and except as provided  
2 in subsection (f) of Section 5-3 of this Act.

3 (15) "Subscriber" means a person who has entered into a  
4 contractual relationship with the Health Maintenance  
5 Organization for the provision of or arrangement of at least  
6 basic health care services to the beneficiaries of such  
7 contract.

8 (Source: P.A. 98-651, eff. 6-16-14; 98-841, eff. 8-1-14;  
9 99-78, eff. 7-20-15.)

10 Section 55. The Illinois Public Aid Code is amended by  
11 changing Sections 5-1.5, 5-2, 5-5, 5-30, 5A-8, 5G-35, 5H-1,  
12 11-22, 11-22a, 11-22b, 11-22c, 12-4.35, 12-4.45, 12-9, and  
13 12-10.4 as follows:

14 (305 ILCS 5/5-1.5)

15 Sec. 5-1.5. COVID-19 public health emergency.  
16 Notwithstanding any other provision of Articles V, XI, and XII  
17 of this Code, the Department may take necessary actions to  
18 address the COVID-19 public health emergency to the extent  
19 such actions are required, approved, or authorized by the  
20 United States Department of Health and Human Services, Centers  
21 for Medicare and Medicaid Services. Such actions may continue  
22 throughout the public health emergency and for up to 12 months  
23 after the period ends, and may include, but are not limited to:  
24 accepting an applicant's or recipient's attestation of income,

1 incurred medical expenses, residency, and insured status when  
2 electronic verification is not available; eliminating resource  
3 tests for some eligibility determinations; suspending  
4 redeterminations; suspending changes that would adversely  
5 affect an applicant's or recipient's eligibility; phone or  
6 verbal approval by an applicant to submit an application in  
7 lieu of applicant signature; allowing adult presumptive  
8 eligibility; allowing presumptive eligibility for children,  
9 pregnant women, and adults as often as twice per calendar  
10 year; paying for additional services delivered by telehealth;  
11 and suspending premium and co-payment requirements.

12 The Department's authority under this Section shall ~~only~~  
13 extend to encompass, incorporate, or effectuate the terms,  
14 items, conditions, and other provisions approved, authorized,  
15 or required by the United States Department of Health and  
16 Human Services, Centers for Medicare and Medicaid Services,  
17 and shall not extend beyond the time of the COVID-19 public  
18 health emergency and up to 12 months after the period expires.

19 Any individual determined eligible for medical assistance  
20 under this Code as of or during the COVID-19 public health  
21 emergency may be treated as eligible for such medical  
22 assistance benefits during the COVID-19 public health  
23 emergency, and up to 12 months after the period expires,  
24 regardless of whether federally required or whether the  
25 individual's eligibility may be State or federally funded,  
26 unless the individual requests a voluntary termination of

1 eligibility or ceases to be a resident. This paragraph shall  
2 not restrict any determination of medical need or  
3 appropriateness for any particular service and shall not  
4 require continued coverage of any particular service that may  
5 be no longer necessary, appropriate, or otherwise authorized  
6 for an individual. Nothing shall prevent the Department from  
7 determining and properly establishing an individual's  
8 eligibility under a different category of eligibility.

9 (Source: P.A. 101-649, eff. 7-7-20.)

10 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

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

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

20 2. Beginning January 1, 2014, persons otherwise  
21 eligible for basic maintenance under Article III,  
22 excluding any eligibility requirements that are  
23 inconsistent with any federal law or federal regulation,  
24 as interpreted by the U.S. Department of Health and Human  
25 Services, but who fail to qualify thereunder on the basis

1 of need, and who have insufficient income and resources to  
2 meet the costs of necessary medical care, including, but  
3 not limited to, the following:

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

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

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

16 (b) (Blank).

17 3. (Blank).

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

23 5.(a) Beginning January 1, 2020, women during  
24 pregnancy and during the 12-month period beginning on the  
25 last day of the pregnancy, together with their infants,  
26 whose income is at or below 200% of the federal poverty



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

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

19 (c) The Illinois Department may conduct a  
20 demonstration in at least one county that will provide  
21 medical assistance to pregnant women, together with their  
22 infants and children up to one year of age, where the  
23 income eligibility standard is set up to 185% of the  
24 nonfarm income official poverty line, as defined by the  
25 federal Office of Management and Budget. The Illinois  
26 Department shall seek and obtain necessary authorization

1 provided under federal law to implement such a  
2 demonstration. Such demonstration may establish resource  
3 standards that are not more restrictive than those  
4 established under Article IV of this Code.

5 6. (a) Subject to federal approval, children ~~Children~~  
6 younger than age 19 when countable income is at or below  
7 313% ~~133%~~ of the federal poverty level, as determined by  
8 the Department and in accordance with all applicable  
9 federal requirements. Until September 30, 2019, or sooner  
10 if the maintenance of effort requirements under the  
11 Patient Protection and Affordable Care Act are eliminated  
12 or may be waived before then, children younger than age 19  
13 whose countable monthly income, after the deduction of  
14 costs incurred for medical care and for other types of  
15 remedial care as specified in administrative rule, is  
16 equal to or less than the Medical Assistance-No Grant(C)  
17 (MANG(C)) Income Standard in effect on April 1, 2013 as  
18 set forth in administrative rule.

19 (b) Children and youth who are under temporary custody  
20 or guardianship of the Department of Children and Family  
21 Services or who receive financial assistance in support of  
22 an adoption or guardianship placement from the Department  
23 of Children and Family Services.

24 7. (Blank).

25 8. As required under federal law, persons who are  
26 eligible for Transitional Medical Assistance as a result

1 of an increase in earnings or child or spousal support  
2 received. The plan for coverage for this class of persons  
3 shall:

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

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

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

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

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

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

23 9. Persons with acquired immunodeficiency syndrome  
24 (AIDS) or with AIDS-related conditions with respect to  
25 whom there has been a determination that but for home or  
26 community-based services such individuals would require

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

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

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

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

24 (b) exempt retirement accounts that the person  
25 cannot access without penalty before the age of 59  
26 1/2, and medical savings accounts established pursuant

1 to 26 U.S.C. 220;

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

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

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

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

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

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

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

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

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

1           may adopt rules governing the implementation of this  
2           paragraph 14.

3           15. Family Care Eligibility.

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

9           (b) Eligibility shall be reviewed annually.

10          (c) (Blank).

11          (d) (Blank).

12          (e) (Blank).

13          (f) (Blank).

14          (g) (Blank).

15          (h) (Blank).

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

20          16. Subject to appropriation, uninsured persons who  
21          are not otherwise eligible under this Section who have  
22          been certified and referred by the Department of Public  
23          Health as having been screened and found to need  
24          diagnostic evaluation or treatment, or both diagnostic  
25          evaluation and treatment, for prostate or testicular  
26          cancer. For the purposes of this paragraph 16, uninsured



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

1 homestead property or other legal or equitable real  
2 property interest owned by a recipient of services under  
3 this paragraph 16.

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

11 (a) Limit the geographic areas in which the waiver  
12 program operates.

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

18 (c) Restrict the persons' freedom in choice of  
19 providers.

20 18. Beginning January 1, 2014, persons aged 19 or  
21 older, but younger than 65, who are not otherwise eligible  
22 for medical assistance under this Section 5-2, who qualify  
23 for medical assistance pursuant to 42 U.S.C.  
24 1396a(a)(10)(A)(i)(VIII) and applicable federal  
25 regulations, and who have income at or below 133% of the  
26 federal poverty level plus 5% for the applicable family

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

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

23 20. Beginning January 1, 2018, persons who are  
24 foreign-born victims of human trafficking, torture, or  
25 other serious crimes as defined in Section 2-19 of this  
26 Code and their derivative family members if such persons:

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

18 21. Persons who are not otherwise eligible for medical  
19 assistance under this Section who may qualify for medical  
20 assistance pursuant to 42 U.S.C.  
21 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the  
22 duration of any federal or State declared emergency due to  
23 COVID-19. Medical assistance to persons eligible for  
24 medical assistance solely pursuant to this paragraph 21  
25 shall be limited to any in vitro diagnostic product (and  
26 the administration of such product) described in 42 U.S.C.

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

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

25 The eligibility of any such person for medical assistance  
26 under this Article is not affected by the payment of any grant

1 under the Senior Citizens and Persons with Disabilities  
2 Property Tax Relief Act or any distributions or items of  
3 income described under subparagraph (X) of paragraph (2) of  
4 subsection (a) of Section 203 of the Illinois Income Tax Act.

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

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

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

24 Notwithstanding any other provision of this Code, if the  
25 United States Supreme Court holds Title II, Subtitle A,  
26 Section 2001(a) of Public Law 111-148 to be unconstitutional,

1 or if a holding of Public Law 111-148 makes Medicaid  
2 eligibility allowed under Section 2001(a) inoperable, the  
3 State or a unit of local government shall be prohibited from  
4 enrolling individuals in the Medical Assistance Program as the  
5 result of federal approval of a State Medicaid waiver on or  
6 after June 14, 2012 (the effective date of Public Act 97-687)  
7 ~~this amendatory Act of the 97th General Assembly~~, and any  
8 individuals enrolled in the Medical Assistance Program  
9 pursuant to eligibility permitted as a result of such a State  
10 Medicaid waiver shall become immediately ineligible.

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

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

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

8           (Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20;  
9 revised 8-24-20.)

10           (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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



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

1 treatment of sickle cell anemia; and (17) any other medical  
2 care, and any other type of remedial care recognized under the  
3 laws of this State. The term "any other type of remedial care"  
4 shall include nursing care and nursing home service for  
5 persons who rely on treatment by spiritual means alone through  
6 prayer for healing.

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

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

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

26 Upon receipt of federal approval of an amendment to the

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

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

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

26 (2) eyeglasses prescribed by a physician skilled in

1 the diseases of the eye, or by an optometrist, whichever  
2 the person may select.

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

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

24 Notwithstanding any other provision of this Code and  
25 subject to federal approval, the Department may adopt rules to  
26 allow a dentist who is volunteering his or her service at no

1 cost to render dental services through an enrolled  
2 not-for-profit health clinic without the dentist personally  
3 enrolling as a participating provider in the medical  
4 assistance program. A not-for-profit health clinic shall  
5 include a public health clinic or Federally Qualified Health  
6 Center or other enrolled provider, as determined by the  
7 Department, through which dental services covered under this  
8 Section are performed. The Department shall establish a  
9 process for payment of claims for reimbursement for covered  
10 dental services rendered under this provision.

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

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

22 The Illinois Department shall authorize the provision of,  
23 and shall authorize payment for, screening by low-dose  
24 mammography for the presence of occult breast cancer for women  
25 35 years of age or older who are eligible for medical  
26 assistance under this Article, as follows:

1 (A) A baseline mammogram for women 35 to 39 years of  
2 age.

3 (B) An annual mammogram for women 40 years of age or  
4 older.

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

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

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

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

22 The Department shall not impose a deductible, coinsurance,  
23 copayment, or any other cost-sharing requirement on the  
24 coverage provided under this paragraph; except that this  
25 sentence does not apply to coverage of diagnostic mammograms  
26 to the extent such coverage would disqualify a high-deductible

1 health plan from eligibility for a health savings account  
2 pursuant to Section 223 of the Internal Revenue Code (26  
3 U.S.C. 223).

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

8 For purposes of this Section:

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

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

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

23 "Breast tomosynthesis" means a radiologic procedure that  
24 involves the acquisition of projection images over the  
25 stationary breast to produce cross-sectional digital  
26 three-dimensional images of the breast.

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

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

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



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

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

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

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

24          The Department shall establish a methodology to remind  
25          women who are age-appropriate for screening mammography, but  
26          who have not received a mammogram within the previous 18

1 months, of the importance and benefit of screening  
2 mammography. The Department shall work with experts in breast  
3 cancer outreach and patient navigation to optimize these  
4 reminders and shall establish a methodology for evaluating  
5 their effectiveness and modifying the methodology based on the  
6 evaluation.

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

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

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

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

21           All medical providers providing medical assistance to  
22 pregnant women under this Code shall receive information from  
23 the Department on the availability of services under any  
24 program providing case management services for addicted women,  
25 including information on appropriate referrals for other  
26 social services that may be needed by addicted women in

1 addition to treatment for addiction.

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

10 Neither the Department of Healthcare and Family Services  
11 nor the Department of Human Services shall sanction the  
12 recipient solely on the basis of her substance abuse.

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

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

1 represented by a sponsor organization. The Department, by  
2 rule, shall develop qualifications for sponsors of  
3 Partnerships. Nothing in this Section shall be construed to  
4 require that the sponsor organization be a medical  
5 organization.

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

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

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

24 (3) Persons receiving medical services through  
25 Partnerships may receive medical and case management  
26 services above the level usually offered through the

1 medical assistance program.

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

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

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

23 The Illinois Department shall require health care  
24 providers to maintain records that document the medical care  
25 and services provided to recipients of Medical Assistance  
26 under this Article. Such records must be retained for a period

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

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

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

23 Notwithstanding any other law to the contrary, the  
24 Illinois Department shall, within 365 days after August 15,  
25 2014 (the effective date of Public Act 98-963), establish  
26 procedures to permit ID/DD facilities licensed under the ID/DD



1 Community Care Act and MC/DD facilities licensed under the  
2 MC/DD Act to submit monthly billing claims for reimbursement  
3 purposes. Following development of these procedures, the  
4 Department shall have an additional 365 days to test the  
5 viability of the new system and to ensure that any necessary  
6 operational or structural changes to its information  
7 technology platforms are implemented.

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

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

25 Enrollment of a vendor shall be subject to a provisional  
26 period and shall be conditional for one year. During the

1 period of conditional enrollment, the Department may terminate  
2 the vendor's eligibility to participate in, or may disenroll  
3 the vendor from, the medical assistance program without cause.  
4 Unless otherwise specified, such termination of eligibility or  
5 disenrollment is not subject to the Department's hearing  
6 process. However, a disenrolled vendor may reapply without  
7 penalty.

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

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

23 The Department shall define or specify the following: (i)  
24 by provider notice, the "category of risk of the vendor" for  
25 each type of vendor, which shall take into account the level of  
26 screening applicable to a particular category of vendor under

1 federal law and regulations; (ii) by rule or provider notice,  
2 the maximum length of the conditional enrollment period for  
3 each category of risk of the vendor; and (iii) by rule, the  
4 hearing rights, if any, afforded to a vendor in each category  
5 of risk of the vendor that is terminated or disenrolled during  
6 the conditional enrollment period.

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

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

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

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

26 (4) In the case of a provider operated by a unit of

1 local government with a population exceeding 3,000,000  
2 when local government funds finance federal participation  
3 for claims payments.

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

11 In the case of long term care facilities, within 45  
12 calendar days of receipt by the facility of required  
13 prescreening information, new admissions with associated  
14 admission documents shall be submitted through the Medical  
15 Electronic Data Interchange (MEDI) or the Recipient  
16 Eligibility Verification (REV) System or shall be submitted  
17 directly to the Department of Human Services using required  
18 admission forms. Effective September 1, 2014, admission  
19 documents, including all prescreening information, must be  
20 submitted through MEDI or REV. Confirmation numbers assigned  
21 to an accepted transaction shall be retained by a facility to  
22 verify timely submittal. Once an admission transaction has  
23 been completed, all resubmitted claims following prior  
24 rejection are subject to receipt no later than 180 days after  
25 the admission transaction has been completed.

26 Claims that are not submitted and received in compliance

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

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

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

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

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

23 The Illinois Department shall establish policies,  
24 procedures, standards and criteria by rule for the  
25 acquisition, repair and replacement of orthotic and prosthetic  
26 devices and durable medical equipment. Such rules shall

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

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

26 In order to promote environmental responsibility, meet the

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



1 authorization conditions on enrollees of managed care  
2 organizations.

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

1 Governor shall establish a workgroup that includes affected  
2 agency representatives and stakeholders representing the  
3 institutional and home and community-based long term care  
4 interests. This Section shall not restrict the Department from  
5 implementing lower level of care eligibility criteria for  
6 community-based services in circumstances where federal  
7 approval has been granted.

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

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

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

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

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

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

26 The period covered by each report shall be the 3 years

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

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

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

21 Because kidney transplantation can be an appropriate,  
22 cost-effective alternative to renal dialysis when medically  
23 necessary and notwithstanding the provisions of Section 1-11  
24 of this Code, beginning October 1, 2014, the Department shall  
25 cover kidney transplantation for noncitizens with end-stage  
26 renal disease who are not eligible for comprehensive medical

1 benefits, who meet the residency requirements of Section 5-3  
2 of this Code, and who would otherwise meet the financial  
3 requirements of the appropriate class of eligible persons  
4 under Section 5-2 of this Code. To qualify for coverage of  
5 kidney transplantation, such person must be receiving  
6 emergency renal dialysis services covered by the Department.  
7 Providers under this Section shall be prior approved and  
8 certified by the Department to perform kidney transplantation  
9 and the services under this Section shall be limited to  
10 services associated with kidney transplantation.

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

22 On or after July 1, 2015, opioid antagonists prescribed  
23 for the treatment of an opioid overdose, including the  
24 medication product, administration devices, and any pharmacy  
25 fees related to the dispensing and administration of the  
26 opioid antagonist, shall be covered under the medical

1 assistance program for persons who are otherwise eligible for  
2 medical assistance under this Article. As used in this  
3 Section, "opioid antagonist" means a drug that binds to opioid  
4 receptors and blocks or inhibits the effect of opioids acting  
5 on those receptors, including, but not limited to, naloxone  
6 hydrochloride or any other similarly acting drug approved by  
7 the U.S. Food and Drug Administration.

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

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

1 dentist and employed by a federally qualified health center.

2 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;  
3 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.  
4 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,  
5 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;  
6 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.  
7 1-1-20; revised 9-18-19.)

8 (305 ILCS 5/5-30)

9 Sec. 5-30. Care coordination.

10 (a) At least 50% of recipients eligible for comprehensive  
11 medical benefits in all medical assistance programs or other  
12 health benefit programs administered by the Department,  
13 ~~including the Children's Health Insurance Program Act and the~~  
14 ~~Covering ALL KIDS Health Insurance Act,~~ shall be enrolled in a  
15 care coordination program by no later than January 1, 2015.  
16 For purposes of this Section, "coordinated care" or "care  
17 coordination" means delivery systems where recipients will  
18 receive their care from providers who participate under  
19 contract in integrated delivery systems that are responsible  
20 for providing or arranging the majority of care, including  
21 primary care physician services, referrals from primary care  
22 physicians, diagnostic and treatment services, behavioral  
23 health services, in-patient and outpatient hospital services,  
24 dental services, and rehabilitation and long-term care  
25 services. The Department shall designate or contract for such

1 integrated delivery systems (i) to ensure enrollees have a  
2 choice of systems and of primary care providers within such  
3 systems; (ii) to ensure that enrollees receive quality care in  
4 a culturally and linguistically appropriate manner; and (iii)  
5 to ensure that coordinated care programs meet the diverse  
6 needs of enrollees with developmental, mental health,  
7 physical, and age-related disabilities.

8 (b) Payment for such coordinated care shall be based on  
9 arrangements where the State pays for performance related to  
10 health care outcomes, the use of evidence-based practices, the  
11 use of primary care delivered through comprehensive medical  
12 homes, the use of electronic medical records, and the  
13 appropriate exchange of health information electronically made  
14 either on a capitated basis in which a fixed monthly premium  
15 per recipient is paid and full financial risk is assumed for  
16 the delivery of services, or through other risk-based payment  
17 arrangements.

18 (c) To qualify for compliance with this Section, the 50%  
19 goal shall be achieved by enrolling medical assistance  
20 enrollees from each medical assistance enrollment category,  
21 including parents, children, seniors, and people with  
22 disabilities to the extent that current State Medicaid payment  
23 laws would not limit federal matching funds for recipients in  
24 care coordination programs. In addition, services must be more  
25 comprehensively defined and more risk shall be assumed than in  
26 the Department's primary care case management program as of

1 January 25, 2011 (the effective date of Public Act 96-1501).

2 (d) The Department shall report to the General Assembly in  
3 a separate part of its annual medical assistance program  
4 report, beginning April, 2012 until April, 2016, on the  
5 progress and implementation of the care coordination program  
6 initiatives established by the provisions of Public Act  
7 96-1501. The Department shall include in its April 2011 report  
8 a full analysis of federal laws or regulations regarding upper  
9 payment limitations to providers and the necessary revisions  
10 or adjustments in rate methodologies and payments to providers  
11 under this Code that would be necessary to implement  
12 coordinated care with full financial risk by a party other  
13 than the Department.

14 (e) Integrated Care Program for individuals with chronic  
15 mental health conditions.

16 (1) The Integrated Care Program shall encompass  
17 services administered to recipients of medical assistance  
18 under this Article to prevent exacerbations and  
19 complications using cost-effective, evidence-based  
20 practice guidelines and mental health management  
21 strategies.

22 (2) The Department may utilize and expand upon  
23 existing contractual arrangements with integrated care  
24 plans under the Integrated Care Program for providing the  
25 coordinated care provisions of this Section.

26 (3) Payment for such coordinated care shall be based



1 on arrangements where the State pays for performance  
2 related to mental health outcomes on a capitated basis in  
3 which a fixed monthly premium per recipient is paid and  
4 full financial risk is assumed for the delivery of  
5 services, or through other risk-based payment arrangements  
6 such as provider-based care coordination.

7 (4) The Department shall examine whether chronic  
8 mental health management programs and services for  
9 recipients with specific chronic mental health conditions  
10 do any or all of the following:

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

13 (B) Lower costs in other aspects of the medical  
14 assistance program, such as hospital admissions,  
15 emergency room visits, or more frequent and  
16 inappropriate psychotropic drug use.

17 (5) The Department shall work with the facilities and  
18 any integrated care plan participating in the program to  
19 identify and correct barriers to the successful  
20 implementation of this subsection (e) prior to and during  
21 the implementation to best facilitate the goals and  
22 objectives of this subsection (e).

23 (f) A hospital that is located in a county of the State in  
24 which the Department mandates some or all of the beneficiaries  
25 of the Medical Assistance Program residing in the county to  
26 enroll in a Care Coordination Program, as set forth in Section

1 5-30 of this Code, shall not be eligible for any non-claims  
2 based payments not mandated by Article V-A of this Code for  
3 which it would otherwise be qualified to receive, unless the  
4 hospital is a Coordinated Care Participating Hospital no later  
5 than 60 days after June 14, 2012 (the effective date of Public  
6 Act 97-689) or 60 days after the first mandatory enrollment of  
7 a beneficiary in a Coordinated Care program. For purposes of  
8 this subsection, "Coordinated Care Participating Hospital"  
9 means a hospital that meets one of the following criteria:

10 (1) The hospital has entered into a contract to  
11 provide hospital services with one or more MCOs to  
12 enrollees of the care coordination program.

13 (2) The hospital has not been offered a contract by a  
14 care coordination plan that the Department has determined  
15 to be a good faith offer and that pays at least as much as  
16 the Department would pay, on a fee-for-service basis, not  
17 including disproportionate share hospital adjustment  
18 payments or any other supplemental adjustment or add-on  
19 payment to the base fee-for-service rate, except to the  
20 extent such adjustments or add-on payments are  
21 incorporated into the development of the applicable MCO  
22 capitated rates.

23 As used in this subsection (f), "MCO" means any entity  
24 which contracts with the Department to provide services where  
25 payment for medical services is made on a capitated basis.

26 (g) No later than August 1, 2013, the Department shall

1 issue a purchase of care solicitation for Accountable Care  
2 Entities (ACE) to serve any children and parents or caretaker  
3 relatives of children eligible for medical assistance under  
4 this Article. An ACE may be a single corporate structure or a  
5 network of providers organized through contractual  
6 relationships with a single corporate entity. The solicitation  
7 shall require that:

8 (1) An ACE operating in Cook County be capable of  
9 serving at least 40,000 eligible individuals in that  
10 county; an ACE operating in Lake, Kane, DuPage, or Will  
11 Counties be capable of serving at least 20,000 eligible  
12 individuals in those counties and an ACE operating in  
13 other regions of the State be capable of serving at least  
14 10,000 eligible individuals in the region in which it  
15 operates. During initial periods of mandatory enrollment,  
16 the Department shall require its enrollment services  
17 contractor to use a default assignment algorithm that  
18 ensures if possible an ACE reaches the minimum enrollment  
19 levels set forth in this paragraph.

20 (2) An ACE must include at a minimum the following  
21 types of providers: primary care, specialty care,  
22 hospitals, and behavioral healthcare.

23 (3) An ACE shall have a governance structure that  
24 includes the major components of the health care delivery  
25 system, including one representative from each of the  
26 groups listed in paragraph (2).

1           (4) An ACE must be an integrated delivery system,  
2 including a network able to provide the full range of  
3 services needed by Medicaid beneficiaries and system  
4 capacity to securely pass clinical information across  
5 participating entities and to aggregate and analyze that  
6 data in order to coordinate care.

7           (5) An ACE must be capable of providing both care  
8 coordination and complex case management, as necessary, to  
9 beneficiaries. To be responsive to the solicitation, a  
10 potential ACE must outline its care coordination and  
11 complex case management model and plan to reduce the cost  
12 of care.

13           (6) In the first 18 months of operation, unless the  
14 ACE selects a shorter period, an ACE shall be paid care  
15 coordination fees on a per member per month basis that are  
16 projected to be cost neutral to the State during the term  
17 of their payment and, subject to federal approval, be  
18 eligible to share in additional savings generated by their  
19 care coordination.

20           (7) In months 19 through 36 of operation, unless the  
21 ACE selects a shorter period, an ACE shall be paid on a  
22 pre-paid capitation basis for all medical assistance  
23 covered services, under contract terms similar to Managed  
24 Care Organizations (MCO), with the Department sharing the  
25 risk through either stop-loss insurance for extremely high  
26 cost individuals or corridors of shared risk based on the

1 overall cost of the total enrollment in the ACE. The ACE  
2 shall be responsible for claims processing, encounter data  
3 submission, utilization control, and quality assurance.

4 (8) In the fourth and subsequent years of operation,  
5 an ACE shall convert to a Managed Care Community Network  
6 (MCCN), as defined in this Article, or Health Maintenance  
7 Organization pursuant to the Illinois Insurance Code,  
8 accepting full-risk capitation payments.

9 The Department shall allow potential ACE entities 5 months  
10 from the date of the posting of the solicitation to submit  
11 proposals. After the solicitation is released, in addition to  
12 the MCO rate development data available on the Department's  
13 website, subject to federal and State confidentiality and  
14 privacy laws and regulations, the Department shall provide 2  
15 years of de-identified summary service data on the targeted  
16 population, split between children and adults, showing the  
17 historical type and volume of services received and the cost  
18 of those services to those potential bidders that sign a data  
19 use agreement. The Department may add up to 2 non-state  
20 government employees with expertise in creating integrated  
21 delivery systems to its review team for the purchase of care  
22 solicitation described in this subsection. Any such  
23 individuals must sign a no-conflict disclosure and  
24 confidentiality agreement and agree to act in accordance with  
25 all applicable State laws.

26 During the first 2 years of an ACE's operation, the

1 Department shall provide claims data to the ACE on its  
2 enrollees on a periodic basis no less frequently than monthly.

3 Nothing in this subsection shall be construed to limit the  
4 Department's mandate to enroll 50% of its beneficiaries into  
5 care coordination systems by January 1, 2015, using all  
6 available care coordination delivery systems, including Care  
7 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed  
8 to affect the current CCEs, MCCNs, and MCOs selected to serve  
9 seniors and persons with disabilities prior to that date.

10 Nothing in this subsection precludes the Department from  
11 considering future proposals for new ACEs or expansion of  
12 existing ACEs at the discretion of the Department.

13 (h) Department contracts with MCOs and other entities  
14 reimbursed by risk based capitation shall have a minimum  
15 medical loss ratio of 85%, shall require the entity to  
16 establish an appeals and grievances process for consumers and  
17 providers, and shall require the entity to provide a quality  
18 assurance and utilization review program. Entities contracted  
19 with the Department to coordinate healthcare regardless of  
20 risk shall be measured utilizing the same quality metrics. The  
21 quality metrics may be population specific. Any contracted  
22 entity serving at least 5,000 seniors or people with  
23 disabilities or 15,000 individuals in other populations  
24 covered by the Medical Assistance Program that has been  
25 receiving full-risk capitation for a year shall be accredited  
26 by a national accreditation organization authorized by the

1 Department within 2 years after the date it is eligible to  
2 become accredited. The requirements of this subsection shall  
3 apply to contracts with MCOs entered into or renewed or  
4 extended after June 1, 2013.

5 (h-5) The Department shall monitor and enforce compliance  
6 by MCOs with agreements they have entered into with providers  
7 on issues that include, but are not limited to, timeliness of  
8 payment, payment rates, and processes for obtaining prior  
9 approval. The Department may impose sanctions on MCOs for  
10 violating provisions of those agreements that include, but are  
11 not limited to, financial penalties, suspension of enrollment  
12 of new enrollees, and termination of the MCO's contract with  
13 the Department. As used in this subsection (h-5), "MCO" has  
14 the meaning ascribed to that term in Section 5-30.1 of this  
15 Code.

16 (i) Unless otherwise required by federal law, Medicaid  
17 Managed Care Entities and their respective business associates  
18 shall not disclose, directly or indirectly, including by  
19 sending a bill or explanation of benefits, information  
20 concerning the sensitive health services received by enrollees  
21 of the Medicaid Managed Care Entity to any person other than  
22 covered entities and business associates, which may receive,  
23 use, and further disclose such information solely for the  
24 purposes permitted under applicable federal and State laws and  
25 regulations if such use and further disclosure satisfies all  
26 applicable requirements of such laws and regulations. The

1 Medicaid Managed Care Entity or its respective business  
2 associates may disclose information concerning the sensitive  
3 health services if the enrollee who received the sensitive  
4 health services requests the information from the Medicaid  
5 Managed Care Entity or its respective business associates and  
6 authorized the sending of a bill or explanation of benefits.  
7 Communications including, but not limited to, statements of  
8 care received or appointment reminders either directly or  
9 indirectly to the enrollee from the health care provider,  
10 health care professional, and care coordinators, remain  
11 permissible. Medicaid Managed Care Entities or their  
12 respective business associates may communicate directly with  
13 their enrollees regarding care coordination activities for  
14 those enrollees.

15 For the purposes of this subsection, the term "Medicaid  
16 Managed Care Entity" includes Care Coordination Entities,  
17 Accountable Care Entities, Managed Care Organizations, and  
18 Managed Care Community Networks.

19 For purposes of this subsection, the term "sensitive  
20 health services" means mental health services, substance abuse  
21 treatment services, reproductive health services, family  
22 planning services, services for sexually transmitted  
23 infections and sexually transmitted diseases, and services for  
24 sexual assault or domestic abuse. Services include prevention,  
25 screening, consultation, examination, treatment, or follow-up.

26 For purposes of this subsection, "business associate",



1 "covered entity", "disclosure", and "use" have the meanings  
2 ascribed to those terms in 45 CFR 160.103.

3 Nothing in this subsection shall be construed to relieve a  
4 Medicaid Managed Care Entity or the Department of any duty to  
5 report incidents of sexually transmitted infections to the  
6 Department of Public Health or to the local board of health in  
7 accordance with regulations adopted under a statute or  
8 ordinance or to report incidents of sexually transmitted  
9 infections as necessary to comply with the requirements under  
10 Section 5 of the Abused and Neglected Child Reporting Act or as  
11 otherwise required by State or federal law.

12 The Department shall create policy in order to implement  
13 the requirements in this subsection.

14 (j) Managed Care Entities (MCEs), including MCOs and all  
15 other care coordination organizations, shall develop and  
16 maintain a written language access policy that sets forth the  
17 standards, guidelines, and operational plan to ensure language  
18 appropriate services and that is consistent with the standard  
19 of meaningful access for populations with limited English  
20 proficiency. The language access policy shall describe how the  
21 MCEs will provide all of the following required services:

22 (1) Translation (the written replacement of text from  
23 one language into another) of all vital documents and  
24 forms as identified by the Department.

25 (2) Qualified interpreter services (the oral  
26 communication of a message from one language into another

1 by a qualified interpreter).

2 (3) Staff training on the language access policy,  
3 including how to identify language needs, access and  
4 provide language assistance services, work with  
5 interpreters, request translations, and track the use of  
6 language assistance services.

7 (4) Data tracking that identifies the language need.

8 (5) Notification to participants on the availability  
9 of language access services and on how to access such  
10 services.

11 (k) The Department shall actively monitor the contractual  
12 relationship between Managed Care Organizations (MCOs) and any  
13 dental administrator contracted by an MCO to provide dental  
14 services. The Department shall adopt appropriate dental  
15 Healthcare Effectiveness Data and Information Set (HEDIS)  
16 measures and shall include the Annual Dental Visit (ADV) HEDIS  
17 measure in its Health Plan Comparison Tool and Illinois  
18 Medicaid Plan Report Card that is available on the  
19 Department's website for enrolled individuals.

20 The Department shall collect from each MCO specific  
21 information about the types of contracted, broad-based care  
22 coordination occurring between the MCO and any dental  
23 administrator, including, but not limited to, pregnant women  
24 and diabetic patients in need of oral care.

25 (Source: P.A. 99-106, eff. 1-1-16; 99-181, eff. 7-29-15;  
26 99-566, eff. 1-1-17; 99-642, eff. 7-28-16; 100-587, eff.

1 6-4-18.)

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

3 Sec. 5A-8. Hospital Provider Fund.

4 (a) There is created in the State Treasury the Hospital  
5 Provider Fund. Interest earned by the Fund shall be credited  
6 to the Fund. The Fund shall not be used to replace any moneys  
7 appropriated to the Medicaid program by the General Assembly.

8 (b) The Fund is created for the purpose of receiving  
9 moneys in accordance with Section 5A-6 and disbursing moneys  
10 only for the following purposes, notwithstanding any other  
11 provision of law:

12 (1) For making payments to hospitals as required under  
13 this Code, ~~under the Children's Health Insurance Program~~  
14 ~~Act, under the Covering ALL KIDS Health Insurance Act,~~ and  
15 under the Long Term Acute Care Hospital Quality  
16 Improvement Transfer Program Act.

17 (2) For the reimbursement of moneys collected by the  
18 Illinois Department from hospitals or hospital providers  
19 through error or mistake in performing the activities  
20 authorized under this Code.

21 (3) For payment of administrative expenses incurred by  
22 the Illinois Department or its agent in performing  
23 activities under this Code, ~~under the Children's Health~~  
24 ~~Insurance Program Act, under the Covering ALL KIDS Health~~  
25 ~~Insurance Act,~~ and under the Long Term Acute Care Hospital

1 Quality Improvement Transfer Program Act.

2 (4) For payments of any amounts which are reimbursable  
3 to the federal government for payments from this Fund  
4 which are required to be paid by State warrant.

5 (5) For making transfers, as those transfers are  
6 authorized in the proceedings authorizing debt under the  
7 Short Term Borrowing Act, but transfers made under this  
8 paragraph (5) shall not exceed the principal amount of  
9 debt issued in anticipation of the receipt by the State of  
10 moneys to be deposited into the Fund.

11 (6) For making transfers to any other fund in the  
12 State treasury, but transfers made under this paragraph  
13 (6) shall not exceed the amount transferred previously  
14 from that other fund into the Hospital Provider Fund plus  
15 any interest that would have been earned by that fund on  
16 the monies that had been transferred.

17 (6.5) For making transfers to the Healthcare Provider  
18 Relief Fund, except that transfers made under this  
19 paragraph (6.5) shall not exceed \$60,000,000 in the  
20 aggregate.

21 (7) For making transfers not exceeding the following  
22 amounts, related to State fiscal years 2013 through 2018,  
23 to the following designated funds:

24	Health and Human Services Medicaid Trust	
25	Fund .....	\$20,000,000
26	Long-Term Care Provider Fund .....	\$30,000,000

1           General Revenue Fund ..... \$80,000,000.  
 2           Transfers under this paragraph shall be made within 7 days  
 3           after the payments have been received pursuant to the  
 4           schedule of payments provided in subsection (a) of Section  
 5           5A-4.

6           (7.1) (Blank).

7           (7.5) (Blank).

8           (7.8) (Blank).

9           (7.9) (Blank).

10          (7.10) For State fiscal year 2014, for making  
 11          transfers of the moneys resulting from the assessment  
 12          under subsection (b-5) of Section 5A-2 and received from  
 13          hospital providers under Section 5A-4 and transferred into  
 14          the Hospital Provider Fund under Section 5A-6 to the  
 15          designated funds not exceeding the following amounts in  
 16          that State fiscal year:

17                 Healthcare Provider Relief Fund..... \$100,000,000

18           Transfers under this paragraph shall be made within 7  
 19           days after the payments have been received pursuant to the  
 20           schedule of payments provided in subsection (a) of Section  
 21           5A-4.

22           The additional amount of transfers in this paragraph  
 23           (7.10), authorized by Public Act 98-651, shall be made  
 24           within 10 State business days after June 16, 2014 (the  
 25           effective date of Public Act 98-651). That authority shall  
 26           remain in effect even if Public Act 98-651 does not become

1 law until State fiscal year 2015.

2 (7.10a) For State fiscal years 2015 through 2018, for  
3 making transfers of the moneys resulting from the  
4 assessment under subsection (b-5) of Section 5A-2 and  
5 received from hospital providers under Section 5A-4 and  
6 transferred into the Hospital Provider Fund under Section  
7 5A-6 to the designated funds not exceeding the following  
8 amounts related to each State fiscal year:

9 Healthcare Provider Relief Fund..... \$50,000,000

10 Transfers under this paragraph shall be made within 7  
11 days after the payments have been received pursuant to the  
12 schedule of payments provided in subsection (a) of Section  
13 5A-4.

14 (7.11) (Blank).

15 (7.12) For State fiscal year 2013, for increasing by  
16 21/365ths the transfer of the moneys resulting from the  
17 assessment under subsection (b-5) of Section 5A-2 and  
18 received from hospital providers under Section 5A-4 for  
19 the portion of State fiscal year 2012 beginning June 10,  
20 2012 through June 30, 2012 and transferred into the  
21 Hospital Provider Fund under Section 5A-6 to the  
22 designated funds not exceeding the following amounts in  
23 that State fiscal year:

24 Healthcare Provider Relief Fund..... \$2,870,000

25 Since the federal Centers for Medicare and Medicaid  
26 Services approval of the assessment authorized under

1 subsection (b-5) of Section 5A-2, received from hospital  
 2 providers under Section 5A-4 and the payment methodologies  
 3 to hospitals required under Section 5A-12.4 was not  
 4 received by the Department until State fiscal year 2014  
 5 and since the Department made retroactive payments during  
 6 State fiscal year 2014 related to the referenced period of  
 7 June 2012, the transfer authority granted in this  
 8 paragraph (7.12) is extended through the date that is 10  
 9 State business days after June 16, 2014 (the effective  
 10 date of Public Act 98-651).

11 (7.13) In addition to any other transfers authorized  
 12 under this Section, for State fiscal years 2017 and 2018,  
 13 for making transfers to the Healthcare Provider Relief  
 14 Fund of moneys collected from the ACA Assessment  
 15 Adjustment authorized under subsections (a) and (b-5) of  
 16 Section 5A-2 and paid by hospital providers under Section  
 17 5A-4 into the Hospital Provider Fund under Section 5A-6  
 18 for each State fiscal year. Timing of transfers to the  
 19 Healthcare Provider Relief Fund under this paragraph shall  
 20 be at the discretion of the Department, but no less  
 21 frequently than quarterly.

22 (7.14) For making transfers not exceeding the  
 23 following amounts, related to State fiscal years 2019 and  
 24 2020, to the following designated funds:

25	Health and Human Services Medicaid Trust	
26	Fund .....	\$20,000,000

1 Long-Term Care Provider Fund ..... \$30,000,000

2 Healthcare Provider Relief Fund.... \$325,000,000.

3 Transfers under this paragraph shall be made within 7  
4 days after the payments have been received pursuant to the  
5 schedule of payments provided in subsection (a) of Section  
6 5A-4.

7 (7.15) For making transfers not exceeding the  
8 following amounts, related to State fiscal years 2021 and  
9 2022, to the following designated funds:

10 Health and Human Services Medicaid Trust

11 Fund ..... \$20,000,000

12 Long-Term Care Provider Fund ..... \$30,000,000

13 Healthcare Provider Relief Fund..... \$365,000,000

14 (7.16) For making transfers not exceeding the  
15 following amounts, related to July 1, 2022 to December 31,  
16 2022, to the following designated funds:

17 Health and Human Services Medicaid Trust

18 Fund ..... \$10,000,000

19 Long-Term Care Provider Fund ..... \$15,000,000

20 Healthcare Provider Relief Fund..... \$182,500,000

21 (8) For making refunds to hospital providers pursuant  
22 to Section 5A-10.

23 (9) For making payment to capitated managed care  
24 organizations as described in subsections (s) and (t) of  
25 Section 5A-12.2, subsection (r) of Section 5A-12.6, and  
26 Section 5A-12.7 of this Code.



1 Disbursements from the Fund, other than transfers  
2 authorized under paragraphs (5) and (6) of this subsection,  
3 shall be by warrants drawn by the State Comptroller upon  
4 receipt of vouchers duly executed and certified by the  
5 Illinois Department.

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

7 (1) All moneys collected or received by the Illinois  
8 Department from the hospital provider assessment imposed  
9 by this Article.

10 (2) All federal matching funds received by the  
11 Illinois Department as a result of expenditures made by  
12 the Illinois Department that are attributable to moneys  
13 deposited in the Fund.

14 (3) Any interest or penalty levied in conjunction with  
15 the administration of this Article.

16 (3.5) As applicable, proceeds from surety bond  
17 payments payable to the Department as referenced in  
18 subsection (s) of Section 5A-12.2 of this Code.

19 (4) Moneys transferred from another fund in the State  
20 treasury.

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

23 (d) (Blank).

24 (Source: P.A. 100-581, eff. 3-12-18; 100-863, eff. 8-14-19;  
25 101-650, eff. 7-7-20.)

1 (305 ILCS 5/5G-35)

2 Sec. 5G-35. Supportive Living Facility Fund.

3 (a) There is created in the State treasury the Supportive  
4 Living Facility Fund. Interest earned by the Fund shall be  
5 credited to the Fund. The Fund shall not be used to replace any  
6 moneys appropriated to the Medicaid program by the General  
7 Assembly.

8 (b) The Fund is created for the purpose of receiving and  
9 disbursing moneys in accordance with this Article.  
10 Disbursements from the Fund, other than transfers authorized  
11 under paragraphs (5) and (6) of this subsection, shall be by  
12 warrants drawn by the State Comptroller upon receipt of  
13 vouchers duly executed and certified by the Department.  
14 Disbursements from the Fund shall be made only as follows:

15 (1) For making payments to supportive living  
16 facilities as required under this Code, ~~under the~~  
17 ~~Children's Health Insurance Program Act, under the~~  
18 ~~Covering ALL KIDS Health Insurance Act,~~ and under the Long  
19 Term Acute Care Hospital Quality Improvement Transfer  
20 Program Act.

21 (2) For the reimbursement of moneys collected by the  
22 Department from supportive living facilities through error  
23 or mistake in performing the activities authorized under  
24 this Code.

25 (3) For payment of administrative expenses incurred by  
26 the Department or its agent in performing administrative

1 oversight activities for the supportive living program or  
2 review of new supportive living facility applications.

3 (4) For payments of any amounts which are reimbursable  
4 to the federal government for payments from this Fund  
5 which are required to be paid by State warrant.

6 (5) For making transfers, as those transfers are  
7 authorized in the proceedings authorizing debt under the  
8 Short Term Borrowing Act, but transfers made under this  
9 paragraph (5) shall not exceed the principal amount of  
10 debt issued in anticipation of the receipt by the State of  
11 moneys to be deposited into the Fund.

12 (6) For making transfers to any other fund in the  
13 State treasury, but transfers made under this paragraph  
14 (6) shall not exceed the amount transferred previously  
15 from that other fund into the Supportive Living Facility  
16 Fund plus any interest that would have been earned by that  
17 fund on the money that had been transferred.

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

19 (1) All moneys collected or received by the Department  
20 from the supportive living facility assessment imposed by  
21 this Article.

22 (2) All moneys collected or received by the Department  
23 from the supportive living facility certification fee  
24 imposed by this Article.

25 (3) All federal matching funds received by the  
26 Department as a result of expenditures made by the

1 Department that are attributable to moneys deposited in  
2 the Fund.

3 (4) Any interest or penalty levied in conjunction with  
4 the administration of this Article.

5 (5) Moneys transferred from another fund in the State  
6 treasury.

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

9 (Source: P.A. 98-651, eff. 6-16-14.)

10 (305 ILCS 5/5H-1)

11 Sec. 5H-1. Definitions. As used in this Article:

12 "Base year" means the 12-month period from January 1, 2018  
13 to December 31, 2018.

14 "Department" means the Department of Healthcare and Family  
15 Services.

16 "Federal employee health benefit" means the program of  
17 health benefits plans, as defined in 5 U.S.C. 8901, available  
18 to federal employees under 5 U.S.C. 8901 to 8914.

19 "Fund" means the Healthcare Provider Relief Fund.

20 "Managed care organization" means an entity operating  
21 under a certificate of authority issued pursuant to the Health  
22 Maintenance Organization Act or as a Managed Care Community  
23 Network pursuant to Section 5-11 of this ~~the Public Aid~~ Code.

24 "Medicaid managed care organization" means a managed care  
25 organization under contract with the Department to provide

1 services to recipients of benefits in the medical assistance  
2 program pursuant to Article V of this ~~the Public Aid Code, the~~  
3 ~~Children's Health Insurance Program Act, or the Covering ALL~~  
4 ~~KIDS Health Insurance Act~~. It does not include contracts the  
5 same entity or an affiliated entity has for other business.

6 "Medicare" means the federal Medicare program established  
7 under Title XVIII of the federal Social Security Act.

8 "Member months" means the aggregate total number of months  
9 all individuals are enrolled for coverage in a Managed Care  
10 Organization during the base year. Member months are  
11 determined by the Department for Medicaid Managed Care  
12 Organizations based on enrollment data in its Medicaid  
13 Management Information System and by the Department of  
14 Insurance for other Managed Care Organizations based on  
15 required filings with the Department of Insurance. Member  
16 months do not include months individuals are enrolled in a  
17 Limited Health Services Organization, including stand-alone  
18 dental or vision plans, a Medicare Advantage Plan, a Medicare  
19 Supplement Plan, a Medicaid Medicare Alignment Initiative Plan  
20 pursuant to a Memorandum of Understanding between the  
21 Department and the Federal Centers for Medicare and Medicaid  
22 Services or a Federal Employee Health Benefits Plan.

23 (Source: P.A. 101-9, eff. 6-5-19; revised 7-12-19.)

24 (305 ILCS 5/11-22) (from Ch. 23, par. 11-22)

25 Sec. 11-22. Charge upon claims and causes of action for

1 injuries. The Illinois Department shall have a charge upon all  
2 claims, demands and causes of action for injuries to an  
3 applicant for or recipient of (i) financial aid under Articles  
4 III, IV, and V or (ii) , ~~(ii) health care benefits provided~~  
5 ~~under the Covering ALL KIDS Health Insurance Act, or (iii)~~  
6 health care benefits provided under the Veterans' Health  
7 Insurance Program Act or the Veterans' Health Insurance  
8 Program Act of 2008 for the total amount of medical assistance  
9 provided the recipient from the time of injury to the date of  
10 recovery upon such claim, demand or cause of action. In  
11 addition, if the applicant or recipient was employable, as  
12 defined by the Department, at the time of the injury, the  
13 Department shall also have a charge upon any such claims,  
14 demands and causes of action for the total amount of aid  
15 provided to the recipient and his dependents, including all  
16 cash assistance and medical assistance only to the extent  
17 includable in the claimant's action, from the time of injury  
18 to the date of recovery upon such claim, demand or cause of  
19 action. Any definition of "employable" adopted by the  
20 Department shall apply only to persons above the age of  
21 compulsory school attendance.

22 If the injured person was employable at the time of the  
23 injury and is provided aid under Articles III, IV, or V and any  
24 dependent or member of his family is provided aid under  
25 Article VI, or vice versa, both the Illinois Department and  
26 the local governmental unit shall have a charge upon such

1 claims, demands and causes of action for the aid provided to  
2 the injured person and any dependent member of his family,  
3 including all cash assistance, medical assistance and food  
4 stamps, from the time of the injury to the date of recovery.

5 "Recipient", as used herein, means (i) in the case of  
6 financial aid provided under this Code, the grantee of record  
7 and any persons whose needs are included in the financial aid  
8 provided to the grantee of record or otherwise met by grants  
9 under the appropriate Article of this Code for which such  
10 person is eligible and (ii) , ~~(ii) in the case of health care~~  
11 ~~benefits provided under the Covering ALL KIDS Health Insurance~~  
12 ~~Act, the child to whom those benefits are provided, and (iii)~~  
13 in the case of health care benefits provided under the  
14 Veterans' Health Insurance Program Act or the Veterans' Health  
15 Insurance Program Act of 2008, the veteran to whom benefits  
16 are provided.

17 In each case, the notice shall be served by certified mail  
18 or registered mail, or by facsimile or electronic messaging  
19 when requested by the party or parties against whom the  
20 applicant or recipient has a claim, demand, or cause of  
21 action, upon the party or parties against whom the applicant  
22 or recipient has a claim, demand or cause of action. The notice  
23 shall claim the charge and describe the interest the Illinois  
24 Department, the local governmental unit, or the county, has in  
25 the claim, demand, or cause of action. The charge shall attach  
26 to any verdict or judgment entered and to any money or property

1 which may be recovered on account of such claim, demand, cause  
2 of action or suit from and after the time of the service of the  
3 notice.

4 On petition filed by the Illinois Department, or by the  
5 local governmental unit or county if either is claiming a  
6 charge, or by the recipient, or by the defendant, the court, on  
7 written notice to all interested parties, may adjudicate the  
8 rights of the parties and enforce the charge. The court may  
9 approve the settlement of any claim, demand or cause of action  
10 either before or after a verdict, and nothing in this Section  
11 shall be construed as requiring the actual trial or final  
12 adjudication of any claim, demand or cause of action upon  
13 which the Illinois Department, the local governmental unit or  
14 county has charge. The court may determine what portion of the  
15 recovery shall be paid to the injured person and what portion  
16 shall be paid to the Illinois Department, the local  
17 governmental unit or county having a charge against the  
18 recovery. In making this determination, the court shall  
19 conduct an evidentiary hearing and shall consider competent  
20 evidence pertaining to the following matters:

21 (1) the amount of the charge sought to be enforced  
22 against the recovery when expressed as a percentage of the  
23 gross amount of the recovery; the amount of the charge  
24 sought to be enforced against the recovery when expressed  
25 as a percentage of the amount obtained by subtracting from  
26 the gross amount of the recovery the total attorney's fees



1 and other costs incurred by the recipient incident to the  
2 recovery; and whether the Department, unit of local  
3 government or county seeking to enforce the charge against  
4 the recovery should as a matter of fairness and equity  
5 bear its proportionate share of the fees and costs  
6 incurred to generate the recovery from which the charge is  
7 sought to be satisfied;

8 (2) the amount, if any, of the attorney's fees and  
9 other costs incurred by the recipient incident to the  
10 recovery and paid by the recipient up to the time of  
11 recovery, and the amount of such fees and costs remaining  
12 unpaid at the time of recovery;

13 (3) the total hospital, doctor and other medical  
14 expenses incurred for care and treatment of the injury to  
15 the date of recovery therefor, the portion of such  
16 expenses theretofore paid by the recipient, by insurance  
17 provided by the recipient, and by the Department, unit of  
18 local government and county seeking to enforce a charge  
19 against the recovery, and the amount of such previously  
20 incurred expenses which remain unpaid at the time of  
21 recovery and by whom such incurred, unpaid expenses are to  
22 be paid;

23 (4) whether the recovery represents less than  
24 substantially full recompense for the injury and the  
25 hospital, doctor and other medical expenses incurred to  
26 the date of recovery for the care and treatment of the

1 injury, so that reduction of the charge sought to be  
2 enforced against the recovery would not likely result in a  
3 double recovery or unjust enrichment to the recipient;

4 (5) the age of the recipient and of persons dependent  
5 for support upon the recipient, the nature and permanency  
6 of the recipient's injuries as they affect not only the  
7 future employability and education of the recipient but  
8 also the reasonably necessary and foreseeable future  
9 material, maintenance, medical, rehabilitative and  
10 training needs of the recipient, the cost of such  
11 reasonably necessary and foreseeable future needs, and the  
12 resources available to meet such needs and pay such costs;

13 (6) the realistic ability of the recipient to repay in  
14 whole or in part the charge sought to be enforced against  
15 the recovery when judged in light of the factors  
16 enumerated above.

17 The burden of producing evidence sufficient to support the  
18 exercise by the court of its discretion to reduce the amount of  
19 a proven charge sought to be enforced against the recovery  
20 shall rest with the party seeking such reduction.

21 The court may reduce and apportion the Illinois  
22 Department's lien proportionate to the recovery of the  
23 claimant. The court may consider the nature and extent of the  
24 injury, economic and noneconomic loss, settlement offers,  
25 comparative negligence as it applies to the case at hand,  
26 hospital costs, physician costs, and all other appropriate

1 costs. The Illinois Department shall pay its pro rata share of  
2 the attorney fees based on the Illinois Department's lien as  
3 it compares to the total settlement agreed upon. This Section  
4 shall not affect the priority of an attorney's lien under the  
5 Attorneys Lien Act. The charges of the Illinois Department  
6 described in this Section, however, shall take priority over  
7 all other liens and charges existing under the laws of the  
8 State of Illinois with the exception of the attorney's lien  
9 under said statute.

10 Whenever the Department or any unit of local government  
11 has a statutory charge under this Section against a recovery  
12 for damages incurred by a recipient because of its advancement  
13 of any assistance, such charge shall not be satisfied out of  
14 any recovery until the attorney's claim for fees is satisfied,  
15 irrespective of whether or not an action based on recipient's  
16 claim has been filed in court.

17 This Section shall be inapplicable to any claim, demand or  
18 cause of action arising under (a) the Workers' Compensation  
19 Act or the predecessor Workers' Compensation Act of June 28,  
20 1913, (b) the Workers' Occupational Diseases Act or the  
21 predecessor Workers' Occupational Diseases Act of March 16,  
22 1936; and (c) the Wrongful Death Act.

23 (Source: P.A. 98-73, eff. 7-15-13.)

24 (305 ILCS 5/11-22a) (from Ch. 23, par. 11-22a)

25 Sec. 11-22a. Right of Subrogation. To the extent of the

1 amount of (i) medical assistance provided by the Department to  
2 or on behalf of a recipient under Article V or VI or (ii) ~~7~~  
3 ~~(ii) health care benefits provided for a child under the~~  
4 ~~Covering ALL KIDS Health Insurance Act, or (iii)~~ health care  
5 benefits provided to a veteran under the Veterans' Health  
6 Insurance Program Act or the Veterans' Health Insurance  
7 Program Act of 2008, the Department shall be subrogated to any  
8 right of recovery such recipient may have under the terms of  
9 any private or public health care coverage or casualty  
10 coverage, including coverage under the "Workers' Compensation  
11 Act", approved July 9, 1951, as amended, or the "Workers'  
12 Occupational Diseases Act", approved July 9, 1951, as amended,  
13 without the necessity of assignment of claim or other  
14 authorization to secure the right of recovery to the  
15 Department. To enforce its subrogation right, the Department  
16 may (i) intervene or join in an action or proceeding brought by  
17 the recipient, his or her guardian, personal representative,  
18 estate, dependents, or survivors against any person or public  
19 or private entity that may be liable; (ii) institute and  
20 prosecute legal proceedings against any person or public or  
21 private entity that may be liable for the cost of such  
22 services; or (iii) institute and prosecute legal proceedings,  
23 to the extent necessary to reimburse the Illinois Department  
24 for its costs, against any noncustodial parent who (A) is  
25 required by court or administrative order to provide insurance  
26 or other coverage of the cost of health care services for a

1 child eligible for medical assistance under this Code and (B)  
2 has received payment from a third party for the costs of those  
3 services but has not used the payments to reimburse either the  
4 other parent or the guardian of the child or the provider of  
5 the services.

6 (Source: P.A. 94-693, eff. 7-1-06; 94-816, eff. 5-30-06;  
7 95-755, eff. 7-25-08.)

8 (305 ILCS 5/11-22b) (from Ch. 23, par. 11-22b)

9 Sec. 11-22b. Recoveries.

10 (a) As used in this Section:

11 (1) "Carrier" means any insurer, including any private  
12 company, corporation, mutual association, trust fund,  
13 reciprocal or interinsurance exchange authorized under the  
14 laws of this State to insure persons against liability or  
15 injuries caused to another and any insurer providing  
16 benefits under a policy of bodily injury liability  
17 insurance covering liability arising out of the ownership,  
18 maintenance or use of a motor vehicle which provides  
19 uninsured motorist endorsement or coverage.

20 (2) "Beneficiary" means any person or their dependents  
21 who has received benefits or will be provided benefits  
22 under this Code, ~~under the Covering ALL KIDS Health~~  
23 ~~Insurance Act,~~ or under the Veterans' Health Insurance  
24 Program Act or the Veterans' Health Insurance Program Act  
25 of 2008 because of an injury for which another person may

1           be liable. It includes such beneficiary's guardian,  
2           conservator or other personal representative, his estate  
3           or survivors.

4           (b) (1) When benefits are provided or will be provided to a  
5           beneficiary under this Code, ~~under the Covering ALL KIDS~~  
6           ~~Health Insurance Act,~~ or under the Veterans' Health Insurance  
7           Program Act or the Veterans' Health Insurance Program Act of  
8           2008 because of an injury for which another person is liable,  
9           or for which a carrier is liable in accordance with the  
10          provisions of any policy of insurance issued pursuant to the  
11          Illinois Insurance Code, the Illinois Department shall have a  
12          right to recover from such person or carrier the reasonable  
13          value of benefits so provided. The Attorney General may, to  
14          enforce such right, institute and prosecute legal proceedings  
15          against the third person or carrier who may be liable for the  
16          injury in an appropriate court, either in the name of the  
17          Illinois Department or in the name of the injured person, his  
18          guardian, personal representative, estate, or survivors.

19          (2) The Department may:

20                (A) compromise or settle and release any such claim  
21                for benefits provided under this Code, or

22                (B) waive any such claims for benefits provided under  
23                this Code, in whole or in part, for the convenience of the  
24                Department or if the Department determines that collection  
25                would result in undue hardship upon the person who  
26                suffered the injury or, in a wrongful death action, upon

1 the heirs of the deceased.

2 (3) No action taken on behalf of the Department pursuant  
3 to this Section or any judgment rendered in such action shall  
4 be a bar to any action upon the claim or cause of action of the  
5 beneficiary, his guardian, conservator, personal  
6 representative, estate, dependents or survivors against the  
7 third person who may be liable for the injury, or shall operate  
8 to deny to the beneficiary the recovery for that portion of any  
9 damages not covered hereunder.

10 (c)(1) When an action is brought by the Department  
11 pursuant to subsection (b), it shall be commenced within the  
12 period prescribed by Article XIII of the Code of Civil  
13 Procedure.

14 However, the Department may not commence the action prior  
15 to 5 months before the end of the applicable period prescribed  
16 by Article XIII of the Code of Civil Procedure. Thirty days  
17 prior to commencing an action, the Department shall notify the  
18 beneficiary of the Department's intent to commence such an  
19 action.

20 (2) The death of the beneficiary does not abate any right  
21 of action established by subsection (b).

22 (3) When an action or claim is brought by persons entitled  
23 to bring such actions or assert such claims against a third  
24 person who may be liable for causing the death of a  
25 beneficiary, any settlement, judgment or award obtained is  
26 subject to the Department's claim for reimbursement of the

1 benefits provided to the beneficiary under this Code, ~~under~~  
2 ~~the Covering ALL KIDS Health Insurance Act,~~ or under the  
3 Veterans' Health Insurance Program Act or the Veterans' Health  
4 Insurance Program Act of 2008.

5 (4) When the action or claim is brought by the beneficiary  
6 alone and the beneficiary incurs a personal liability to pay  
7 attorney's fees and costs of litigation, the Department's  
8 claim for reimbursement of the benefits provided to the  
9 beneficiary shall be the full amount of benefits paid on  
10 behalf of the beneficiary under this Code, ~~under the Covering~~  
11 ~~ALL KIDS Health Insurance Act,~~ or under the Veterans' Health  
12 Insurance Program Act or the Veterans' Health Insurance  
13 Program Act of 2008 less a pro rata share which represents the  
14 Department's reasonable share of attorney's fees paid by the  
15 beneficiary and that portion of the cost of litigation  
16 expenses determined by multiplying by the ratio of the full  
17 amount of the expenditures of the full amount of the judgment,  
18 award or settlement.

19 (d)(1) If either the beneficiary or the Department brings  
20 an action or claim against such third party or carrier, the  
21 beneficiary or the Department shall within 30 days of filing  
22 the action give to the other written notice by personal  
23 service or registered mail of the action or claim and of the  
24 name of the court in which the action or claim is brought.  
25 Proof of such notice shall be filed in such action or claim. If  
26 an action or claim is brought by either the Department or the



1 beneficiary, the other may, at any time before trial on the  
2 facts, become a party to such action or claim or shall  
3 consolidate his action or claim with the other if brought  
4 independently.

5 (2) If an action or claim is brought by the Department  
6 pursuant to subsection (b)(1), written notice to the  
7 beneficiary, guardian, personal representative, estate or  
8 survivor given pursuant to this Section shall advise him of  
9 his right to intervene in the proceeding, his right to obtain a  
10 private attorney of his choice and the Department's right to  
11 recover the reasonable value of the benefits provided.

12 (e) In the event of judgment or award in a suit or claim  
13 against such third person or carrier:

14 (1) If the action or claim is prosecuted by the  
15 beneficiary alone, the court shall first order paid from  
16 any judgment or award the reasonable litigation expenses  
17 incurred in preparation and prosecution of such action or  
18 claim, together with reasonable attorney's fees, when an  
19 attorney has been retained. After payment of such expenses  
20 and attorney's fees the court shall, on the application of  
21 the Department, allow as a first lien against the amount  
22 of such judgment or award the amount of the Department's  
23 expenditures for the benefit of the beneficiary under this  
24 Code, ~~under the Covering ALL KIDS Health Insurance Act,~~ or  
25 under the Veterans' Health Insurance Program Act or the  
26 Veterans' Health Insurance Program Act of 2008, as

1 provided in subsection (c) (4).

2 (2) If the action or claim is prosecuted both by the  
3 beneficiary and the Department, the court shall first  
4 order paid from any judgment or award the reasonable  
5 litigation expenses incurred in preparation and  
6 prosecution of such action or claim, together with  
7 reasonable attorney's fees for plaintiffs attorneys based  
8 solely on the services rendered for the benefit of the  
9 beneficiary. After payment of such expenses and attorney's  
10 fees, the court shall apply out of the balance of such  
11 judgment or award an amount sufficient to reimburse the  
12 Department the full amount of benefits paid on behalf of  
13 the beneficiary under this Code, ~~under the Covering ALL~~  
14 ~~KIDS Health Insurance Act,~~ or under the Veterans' Health  
15 Insurance Program Act or the Veterans' Health Insurance  
16 Program Act of 2008.

17 (f) The court shall, upon further application at any time  
18 before the judgment or award is satisfied, allow as a further  
19 lien the amount of any expenditures of the Department in  
20 payment of additional benefits arising out of the same cause  
21 of action or claim provided on behalf of the beneficiary under  
22 this Code, ~~under the Covering ALL KIDS Health Insurance Act,~~  
23 or under the Veterans' Health Insurance Program Act or the  
24 Veterans' Health Insurance Program Act of 2008, when such  
25 benefits were provided or became payable subsequent to the  
26 original order.

1           (g) No judgment, award, or settlement in any action or  
2 claim by a beneficiary to recover damages for injuries, when  
3 the Department has an interest, shall be satisfied without  
4 first giving the Department notice and a reasonable  
5 opportunity to perfect and satisfy its lien.

6           (h) When the Department has perfected a lien upon a  
7 judgment or award in favor of a beneficiary against any third  
8 party for an injury for which the beneficiary has received  
9 benefits under this Code, ~~under the Covering ALL KIDS Health~~  
10 ~~Insurance Act,~~ or under the Veterans' Health Insurance Program  
11 Act or the Veterans' Health Insurance Program Act of 2008, the  
12 Department shall be entitled to a writ of execution as lien  
13 claimant to enforce payment of said lien against such third  
14 party with interest and other accruing costs as in the case of  
15 other executions. In the event the amount of such judgment or  
16 award so recovered has been paid to the beneficiary, the  
17 Department shall be entitled to a writ of execution against  
18 such beneficiary to the extent of the Department's lien, with  
19 interest and other accruing costs as in the case of other  
20 executions.

21           (i) Except as otherwise provided in this Section,  
22 notwithstanding any other provision of law, the entire amount  
23 of any settlement of the injured beneficiary's action or  
24 claim, with or without suit, is subject to the Department's  
25 claim for reimbursement of the benefits provided and any lien  
26 filed pursuant thereto to the same extent and subject to the

1 same limitations as in Section 11-22 of this Code.

2 (Source: P.A. 94-693, eff. 7-1-06; 94-816, eff. 5-30-06;  
3 95-755, eff. 7-25-08.)

4 (305 ILCS 5/11-22c) (from Ch. 23, par. 11-22c)

5 Sec. 11-22c. Recovery of back wages.

6 (a) As used in this Section, "recipient" means any person  
7 receiving financial assistance under Article IV or Article VI  
8 of this Code, ~~receiving health care benefits under the~~  
9 ~~Covering ALL KIDS Health Insurance Act,~~ or receiving health  
10 care benefits under the Veterans' Health Insurance Program Act  
11 or the Veterans' Health Insurance Program Act of 2008.

12 (b) If a recipient maintains any suit, charge or other  
13 court or administrative action against an employer seeking  
14 back pay for a period during which the recipient received  
15 financial assistance under Article IV or Article VI of this  
16 Code, ~~health care benefits under the Covering ALL KIDS Health~~  
17 ~~Insurance Act,~~ or health care benefits under the Veterans'  
18 Health Insurance Program Act or the Veterans' Health Insurance  
19 Program Act of 2008, the recipient shall report such fact to  
20 the Department. To the extent of the amount of assistance  
21 provided to or on behalf of the recipient under Article IV or  
22 Article VI, ~~health care benefits provided under the Covering~~  
23 ~~ALL KIDS Health Insurance Act,~~ or health care benefits  
24 provided under the Veterans' Health Insurance Program Act or  
25 the Veterans' Health Insurance Program Act of 2008, the

1 Department may by intervention or otherwise without the  
2 necessity of assignment of claim, attach a lien on the  
3 recovery of back wages equal to the amount of assistance  
4 provided by the Department to the recipient under Article IV  
5 or Article VI, ~~under the Covering ALL KIDS Health Insurance~~  
6 ~~Act,~~ or under the Veterans' Health Insurance Program Act or  
7 the Veterans' Health Insurance Program Act of 2008.

8 (Source: P.A. 94-693, eff. 7-1-06; 94-816, eff. 5-30-06;  
9 95-755, eff. 7-25-08.)

10 (305 ILCS 5/12-4.35)

11 Sec. 12-4.35. Medical services for certain noncitizens.

12 (a) Notwithstanding Section 1-11 of this Code ~~or Section~~  
13 ~~20(a) of the Children's Health Insurance Program Act,~~ the  
14 Department of Healthcare and Family Services may provide  
15 medical services to noncitizens who have not yet attained 19  
16 years of age and who are not eligible for medical assistance  
17 under Article V of this Code ~~or under the Children's Health~~  
18 ~~Insurance Program created by the Children's Health Insurance~~  
19 ~~Program Act~~ due to their not meeting the otherwise applicable  
20 provisions of Section 1-11 of this Code ~~or Section 20(a) of the~~  
21 ~~Children's Health Insurance Program Act.~~ The medical services  
22 available, standards for eligibility, and other conditions of  
23 participation under this Section shall be established by rule  
24 by the Department; however, any such rule shall be at least as  
25 restrictive as the rules for medical assistance under Article

1 V of this Code ~~or the Children's Health Insurance Program~~  
2 ~~created by the Children's Health Insurance Program Act.~~

3 (a-5) Notwithstanding Section 1-11 of this Code, the  
4 Department of Healthcare and Family Services may provide  
5 medical assistance in accordance with Article V of this Code  
6 to noncitizens over the age of 65 years of age who are not  
7 eligible for medical assistance under Article V of this Code  
8 due to their not meeting the otherwise applicable provisions  
9 of Section 1-11 of this Code, whose income is at or below 100%  
10 of the federal poverty level after deducting the costs of  
11 medical or other remedial care, and who would otherwise meet  
12 the eligibility requirements in Section 5-2 of this Code. The  
13 medical services available, standards for eligibility, and  
14 other conditions of participation under this Section shall be  
15 established by rule by the Department; however, any such rule  
16 shall be at least as restrictive as the rules for medical  
17 assistance under Article V of this Code.

18 (b) The Department is authorized to take any action that  
19 would not otherwise be prohibited by applicable law, including  
20 without limitation cessation or limitation of enrollment,  
21 reduction of available medical services, and changing  
22 standards for eligibility, that is deemed necessary by the  
23 Department during a State fiscal year to assure that payments  
24 under this Section do not exceed available funds.

25 (c) (Blank). ~~Continued enrollment of individuals into the~~  
26 ~~program created under subsection (a) of this Section in any~~

1 ~~fiscal year is contingent upon continued enrollment of~~  
2 ~~individuals into the Children's Health Insurance Program~~  
3 ~~during that fiscal year.~~

4 (d) (Blank).

5 (Source: P.A. 101-636, eff. 6-10-20.)

6 (305 ILCS 5/12-4.45)

7 Sec. 12-4.45. Third party liability.

8 (a) To the extent authorized under federal law, the  
9 Department of Healthcare and Family Services shall identify  
10 individuals receiving services under medical assistance  
11 programs funded or partially funded by the State who may be or  
12 may have been covered by a third party health insurer, the  
13 period of coverage for such individuals, and the nature of  
14 coverage. A company, as defined in Section 5.5 of the Illinois  
15 Insurance Code and Section 2 of the Comprehensive Health  
16 Insurance Plan Act, must provide the Department eligibility  
17 information in a federally recommended or mutually agreed-upon  
18 format that includes at a minimum:

19 (1) The names, addresses, dates, and sex of primary  
20 covered persons.

21 (2) The policy group numbers of the covered persons.

22 (3) The names, dates of birth, and sex of covered  
23 dependents, and the relationship of dependents to the  
24 primary covered person.

25 (4) The effective dates of coverage for each covered

1 person.

2 (5) The generally defined covered services  
3 information, such as drugs, medical, or any other similar  
4 description of services covered.

5 (b) The Department may impose an administrative penalty on  
6 a company that does not comply with the request for  
7 information made under Section 5.5 of the Illinois Insurance  
8 Code ~~and paragraph (3) of subsection (a) of Section 20 of the~~  
9 ~~Covering ALL KIDS Health Insurance Act.~~ The amount of the  
10 penalty shall not exceed \$10,000 per day for each day of  
11 noncompliance that occurs after the 180th day after the date  
12 of the request. The first day of the 180-day period commences  
13 on the business day following the date of the correspondence  
14 requesting the information sent by the Department to the  
15 company. The amount shall be based on:

16 (1) The seriousness of the violation, including the  
17 nature, circumstances, extent, and gravity of the  
18 violation.

19 (2) The economic harm caused by the violation.

20 (3) The history of previous violations.

21 (4) The amount necessary to deter a future violation.

22 (5) Efforts to correct the violation.

23 (6) Any other matter that justice may require.

24 (c) The enforcement of the penalty may be stayed during  
25 the time the order is under administrative review if the  
26 company files an appeal.



1 (d) The Attorney General may bring suit on behalf of the  
2 Department to collect the penalty.

3 (e) Recoveries made by the Department in connection with  
4 the imposition of an administrative penalty as provided under  
5 this Section shall be deposited into the Public Aid Recoveries  
6 Trust Fund created under Section 12-9.

7 (Source: P.A. 98-130, eff. 8-2-13; 98-756, eff. 7-16-14.)

8 (305 ILCS 5/12-9) (from Ch. 23, par. 12-9)

9 Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The  
10 Public Aid Recoveries Trust Fund shall consist of (1)  
11 recoveries by the Department of Healthcare and Family Services  
12 (formerly Illinois Department of Public Aid) authorized by  
13 this Code in respect to applicants or recipients under  
14 Articles III, IV, V, and VI, including recoveries made by the  
15 Department of Healthcare and Family Services (formerly  
16 Illinois Department of Public Aid) from the estates of  
17 deceased recipients, (2) ~~recoveries made by the Department of~~  
18 ~~Healthcare and Family Services (formerly Illinois Department~~  
19 ~~of Public Aid) in respect to applicants and recipients under~~  
20 ~~the Children's Health Insurance Program Act, and the Covering~~  
21 ~~ALL KIDS Health Insurance Act, (2.5)~~ recoveries made by the  
22 Department of Healthcare and Family Services in connection  
23 with the imposition of an administrative penalty as provided  
24 under Section 12-4.45, (3) federal funds received on behalf of  
25 and earned by State universities and local governmental

1 entities for services provided to applicants or recipients  
2 covered under this Code, ~~the Children's Health Insurance~~  
3 ~~Program Act, and the Covering ALL KIDS Health Insurance Act,~~  
4 (3.5) federal financial participation revenue related to  
5 eligible disbursements made by the Department of Healthcare  
6 and Family Services from appropriations required by this  
7 Section, and (4) all other moneys received to the Fund,  
8 including interest thereon. The Fund shall be held as a  
9 special fund in the State Treasury.

10 Disbursements from this Fund shall be only (1) for the  
11 reimbursement of claims collected by the Department of  
12 Healthcare and Family Services (formerly Illinois Department  
13 of Public Aid) through error or mistake, (2) for payment to  
14 persons or agencies designated as payees or co-payees on any  
15 instrument, whether or not negotiable, delivered to the  
16 Department of Healthcare and Family Services (formerly  
17 Illinois Department of Public Aid) as a recovery under this  
18 Section, such payment to be in proportion to the respective  
19 interests of the payees in the amount so collected, (3) for  
20 payments to the Department of Human Services for collections  
21 made by the Department of Healthcare and Family Services  
22 (formerly Illinois Department of Public Aid) on behalf of the  
23 Department of Human Services under this Code, ~~the Children's~~  
24 ~~Health Insurance Program Act, and the Covering ALL KIDS Health~~  
25 ~~Insurance Act,~~ (4) for payment of administrative expenses  
26 incurred in performing the activities authorized under this

1 Code, ~~the Children's Health Insurance Program Act, and the~~  
2 ~~Covering ALL KIDS Health Insurance Act,~~ (5) for payment of  
3 fees to persons or agencies in the performance of activities  
4 pursuant to the collection of monies owed the State that are  
5 collected under this Code, ~~the Children's Health Insurance~~  
6 ~~Program Act, and the Covering ALL KIDS Health Insurance Act,~~  
7 (6) for payments of any amounts which are reimbursable to the  
8 federal government which are required to be paid by State  
9 warrant by either the State or federal government, and (7) for  
10 payments to State universities and local governmental entities  
11 of federal funds for services provided to applicants or  
12 recipients covered under this Code, ~~the Children's Health~~  
13 ~~Insurance Program Act, and the Covering ALL KIDS Health~~  
14 ~~Insurance Act.~~ Disbursements from this Fund for purposes of  
15 items (4) and (5) of this paragraph shall be subject to  
16 appropriations from the Fund to the Department of Healthcare  
17 and Family Services (formerly Illinois Department of Public  
18 Aid).

19 The balance in this Fund after payment therefrom of any  
20 amounts reimbursable to the federal government, and minus the  
21 amount reasonably anticipated to be needed to make the  
22 disbursements authorized by this Section during the current  
23 and following 3 calendar months, 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  
26 Healthcare Provider Relief Fund in the State Treasury, as

1 appropriate, on at least an annual basis by June 30th of each  
2 fiscal year. The Director of Healthcare and Family Services  
3 may certify and the State Comptroller shall transfer to the  
4 Drug Rebate Fund or the Healthcare Provider Relief Fund  
5 amounts on a more frequent basis.

6 On July 1, 1999, the State Comptroller shall transfer the  
7 sum of \$5,000,000 from the Public Aid Recoveries Trust Fund  
8 (formerly the Public Assistance Recoveries Trust Fund) into  
9 the DHS Recoveries Trust Fund.

10 (Source: P.A. 97-647, eff. 1-1-12; 97-689, eff. 6-14-12;  
11 98-130, eff. 8-2-13; 98-651, eff. 6-16-14.)

12 (305 ILCS 5/12-10.4)

13 Sec. 12-10.4. Juvenile Rehabilitation Services Medicaid  
14 Matching Fund. There is created in the State Treasury the  
15 Juvenile Rehabilitation Services Medicaid Matching Fund.  
16 Deposits to this Fund shall consist of all moneys received  
17 from the federal government for behavioral health services  
18 secured by counties pursuant to an agreement with the  
19 Department of Healthcare and Family Services with respect to  
20 Title XIX of the Social Security Act ~~or under the Children's~~  
21 ~~Health Insurance Program pursuant to the Children's Health~~  
22 ~~Insurance Program Act and Title XXI of the Social Security Act~~  
23 for minors who are committed to mental health facilities by  
24 the Illinois court system and for residential placements  
25 secured by the Department of Juvenile Justice for minors as a

1 condition of their aftercare release.

2 Disbursements from the Fund shall be made, subject to  
3 appropriation, by the Department of Healthcare and Family  
4 Services for grants to the Department of Juvenile Justice and  
5 those counties which secure behavioral health services ordered  
6 by the courts and which have an interagency agreement with the  
7 Department and submit detailed bills according to standards  
8 determined by the Department.

9 (Source: P.A. 98-558, eff. 1-1-14.)

10 (305 ILCS 5/5-29 rep.)

11 Section 60. The Illinois Public Aid Code is amended by  
12 repealing Section 5-29.

13 Section 65. The Early Intervention Services System Act is  
14 amended by changing Section 13.5 as follows:

15 (325 ILCS 20/13.5)

16 Sec. 13.5. Other programs.

17 (a) When an application or a review of eligibility for  
18 early intervention services is made, and at any eligibility  
19 redetermination thereafter, the family shall be asked if it is  
20 currently enrolled in any federally funded, Department of  
21 Healthcare and Family Services administered, medical programs,  
22 or the Title V program administered by the University of  
23 Illinois Division of Specialized Care for Children. If the

1 family is enrolled in any of these programs, that information  
2 shall be put on the individualized family service plan and  
3 entered into the computerized case management system, and  
4 shall require that the individualized family services plan of  
5 a child who has been found eligible for services through the  
6 Division of Specialized Care for Children state that the child  
7 is enrolled in that program. For those programs in which the  
8 family is not enrolled, a preliminary eligibility screen shall  
9 be conducted simultaneously for (i) medical assistance  
10 (Medicaid) under Article V of the Illinois Public Aid Code and  
11 (ii) , ~~(ii) children's health insurance program (any federally~~  
12 ~~funded, Department of Healthcare and Family Services~~  
13 ~~administered, medical programs) benefits under the Children's~~  
14 ~~Health Insurance Program Act, and (iii)~~ Title V maternal and  
15 child health services provided through the Division of  
16 Specialized Care for Children of the University of Illinois.

17 (b) For purposes of determining family fees under  
18 subsection (f) of Section 13 and determining eligibility for  
19 the other programs and services specified in items (i) through  
20 (iii) of subsection (a), the lead agency shall develop and  
21 use, within 60 days after the effective date of this  
22 amendatory Act of the 92nd General Assembly, with the  
23 cooperation of the Department of Public Aid (now Healthcare  
24 and Family Services) and the Division of Specialized Care for  
25 Children of the University of Illinois, a screening device  
26 that provides sufficient information for the early

1 intervention regional intake entities or other agencies to  
2 establish eligibility for those other programs and shall, in  
3 cooperation with the Illinois Department of Public Aid (now  
4 Healthcare and Family Services) and the Division of  
5 Specialized Care for Children, train the regional intake  
6 entities on using the screening device.

7 (c) When a child is determined eligible for and enrolled  
8 in the early intervention program and has been found to at  
9 least meet the threshold income eligibility requirements for  
10 any federally funded, Department of Healthcare and Family  
11 Services administered, medical programs, the regional intake  
12 entity shall complete an application for any federally funded,  
13 Department of Healthcare and Family Services administered,  
14 medical programs with the family and forward it to the  
15 Department of Healthcare and Family Services for a  
16 determination of eligibility. A parent shall not be required  
17 to enroll in any federally funded, Department of Healthcare  
18 and Family Services administered, medical programs as a  
19 condition of receiving services provided pursuant to Part C of  
20 the Individuals with Disabilities Education Act.

21 (d) With the cooperation of the Department of Healthcare  
22 and Family Services, the lead agency shall establish  
23 procedures that ensure the timely and maximum allowable  
24 recovery of payments for all early intervention services and  
25 allowable administrative costs under Article V of the Illinois  
26 Public Aid Code ~~and the Children's Health Insurance Program~~

1 ~~Act~~ and shall include those procedures in the interagency  
2 agreement required under subsection (e) of Section 5 of this  
3 Act.

4 (e) (Blank). ~~For purposes of making referrals for final~~  
5 ~~determinations of eligibility for any federally funded,~~  
6 ~~Department of Healthcare and Family Services administered,~~  
7 ~~medical programs benefits under the Children's Health~~  
8 ~~Insurance Program Act and for medical assistance under Article~~  
9 ~~V of the Illinois Public Aid Code, the lead agency shall~~  
10 ~~require each early intervention regional intake entity to~~  
11 ~~enroll as an application agent in order for the entity to~~  
12 ~~complete any federally funded, Department of Healthcare and~~  
13 ~~Family Services administered, medical programs application as~~  
14 ~~authorized under Section 22 of the Children's Health Insurance~~  
15 ~~Program Act.~~

16 (f) For purposes of early intervention services that may  
17 be provided by the Division of Specialized Care for Children  
18 of the University of Illinois (DSCC), the lead agency shall  
19 establish procedures whereby the early intervention regional  
20 intake entities may determine whether children enrolled in the  
21 early intervention program may also be eligible for those  
22 services, and shall develop, within 60 days after the  
23 effective date of this amendatory Act of the 92nd General  
24 Assembly, (i) the inter-agency agreement required under  
25 subsection (e) of Section 5 of this Act, establishing that  
26 early intervention funds are to be used as the payor of last



1 resort when services required under an individualized family  
2 services plan may be provided to an eligible child through the  
3 DSCC, and (ii) training guidelines for the regional intake  
4 entities and providers that explain eligibility and billing  
5 procedures for services through DSCC.

6 (g) The lead agency shall require that an individual  
7 applying for or renewing enrollment as a provider of services  
8 in the early intervention program state whether or not he or  
9 she is also enrolled as a DSCC provider. This information  
10 shall be noted next to the name of the provider on the  
11 computerized roster of Illinois early intervention providers,  
12 and regional intake entities shall make every effort to refer  
13 families eligible for DSCC services to these providers.

14 (Source: P.A. 98-41, eff. 6-28-13.)

15 Section 70. The Veterans' Health Insurance Program Act of  
16 2008 is amended by changing Section 15 as follows:

17 (330 ILCS 126/15)

18 Sec. 15. Eligibility.

19 (a) To be eligible for the Program, a person must:

20 (1) be a veteran who is not on active duty and who has  
21 not been dishonorably discharged from service or the  
22 spouse of such a veteran;

23 (2) be a resident of the State of Illinois;

24 (3) be at least 19 years of age and no older than 64

1 years of age;

2 (4) be uninsured, as defined by the Department by  
3 rule, for a period of time established by the Department  
4 by rule, which shall be no less than 3 months;

5 (5) not be eligible for medical assistance under the  
6 Illinois Public Aid Code ~~or healthcare benefits under the~~  
7 ~~Children's Health Insurance Program Act or the Covering~~  
8 ~~ALL KIDS Health Insurance Act;~~

9 (6) not be eligible for medical benefits through the  
10 Veterans Health Administration; and

11 (7) have a household income no greater than the sum of  
12 (i) an amount equal to 25% of the federal poverty level  
13 plus (ii) an amount equal to the Veterans Administration  
14 means test income threshold at the initiation of the  
15 Program; depending on the availability of funds, this  
16 level may be increased to an amount equal to the sum of  
17 (iii) an amount equal to 50% of the federal poverty level  
18 plus (iv) an amount equal to the Veterans Administration  
19 means test income threshold. This means test income  
20 threshold is subject to alteration by the Department as  
21 set forth in subsection (b) of Section 10.

22 (b) A veteran or spouse who is determined eligible for the  
23 Program shall remain eligible for 12 months, provided the  
24 veteran or spouse remains a resident of the State and is not  
25 excluded under subsection (c) of this Section and provided the  
26 Department has not limited the enrollment period as set forth

1 in subsection (b) of Section 10.

2 (c) A veteran or spouse is not eligible for coverage under  
3 the Program if:

4 (1) the premium required under Section 35 of this Act  
5 has not been timely paid; if the required premiums are not  
6 paid, the liability of the Program shall be limited to  
7 benefits incurred under the Program for the time period  
8 for which premiums have been paid and for grace periods as  
9 established under subsection (d); if the required monthly  
10 premium is not paid, the veteran or spouse is ineligible  
11 for re-enrollment for a minimum period of 3 months; or

12 (2) the veteran or spouse is a resident of a nursing  
13 facility or an inmate of a public institution, as defined  
14 by 42 CFR 435.1009.

15 (d) The Department shall adopt rules for the Program,  
16 including, but not limited to, rules relating to eligibility,  
17 re-enrollment, grace periods, notice requirements, hearing  
18 procedures, cost-sharing, covered services, and provider  
19 requirements.

20 (Source: P.A. 95-755, eff. 7-25-08; 96-45, eff. 7-15-09.)

21 (215 ILCS 106/Act rep.)

22 Section 75. The Children's Health Insurance Program Act is  
23 repealed.

24 (215 ILCS 170/Act rep.)

1           Section 80. The Covering ALL KIDS Health Insurance Act is  
2    repealed.

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