HB3119

LRB10214580KTG19933b

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.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

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

(30 ILCS 105/6z-52)

Sec. 6z-52. Drug Rebate Fund.

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

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

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

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

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

Illinois Department of Public Aid) through error or mistake.

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

(30 ILCS 105/6z-81)

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

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

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

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

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

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 25. Fiscal year limitations.

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

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

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

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

(b-2) (Blank).

(b-2.5) (Blank).

(b-2.6) (Blank).

(b-2.6a) (Blank).

(b-2.6b) (Blank).

(b-2.6c) (Blank).

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

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

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

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

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

business on October 31.

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

(b-6) (Blank).

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

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

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

(b-9) (Blank).

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

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

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

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

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

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

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

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

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

of medical services.

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

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

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

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

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

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

User agencies are authorized to reimburse internal service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Definition of Medical Assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

(30 ILCS 540/3-2)

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

following:

(1) Any bill, except a bill submitted under Article V of the Illinois Public Aid Code and except as provided under paragraph (1.05) of this Section, approved for payment under this Section must be paid or the payment issued to the payee within 60 days of receipt of a proper bill or invoice. If payment is not issued to the payee within this 60-day period, an interest penalty of 1.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60-day period, until final payment is made. Any bill, except a bill for pharmacy or nursing facility services or goods, and except as provided under paragraph (1.05) of this Section, submitted under Article V of the Illinois Public Aid Code approved for payment under this Section must be paid or the payment issued to the payee within 60 days after receipt of a proper bill or invoice, and, if payment is not issued to the payee within this 60-day period, an interest penalty of 2.0% of any amount approved and unpaid shall be added for each month or fraction thereof after the end of this 60-day period, until final payment is made. Any bill for pharmacy or nursing facility services or goods submitted under Article V of the Illinois Public Aid Code, except as provided under paragraph (1.05) of this Section, and approved for payment under this Section must be paid or the payment issued to the payee within 60

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

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

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

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

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

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

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

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

during the pendency of the Auditor General's review.

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

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

(35 ILCS 105/3-8)

Sec. 3-8. Hospital exemption.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) (Blank).

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

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

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

(B) the applicable State equalization rate

(yielding the equalized assessed value), by

(C) the applicable tax rate.

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

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

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

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

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

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

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

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

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

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

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

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

control or ownership.

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

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

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

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

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

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

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

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

(35 ILCS 110/3-8)

Sec. 3-8. Hospital exemption.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) For purposes of making the calculations required by

this Section:

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

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

(f) (Blank).

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

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

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

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

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

(C) the applicable tax rate.

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

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

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

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

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

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

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

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

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

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

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

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

hospitals.

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

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

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

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

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

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

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

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

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

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

(35 ILCS 120/2-9)

Sec. 2-9. Hospital exemption.

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

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

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

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

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

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

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

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

payments to the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance~~, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program~~ or (B) the amount of subsidy provided by the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) to State or local government in treating Medicaid recipients and recipients of means-tested programs, including but not limited to General Assistance~~, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program~~. The amount of subsidy for purposes of this item (4) is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly.

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

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

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

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

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

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

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

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

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

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

(f) (Blank).

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

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

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

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

(C) the applicable tax rate.

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

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

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

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

(3) The assessment factor, State equalization rate,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(35 ILCS 200/15-86)

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

(a) The General Assembly finds:

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

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

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

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

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

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

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

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

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

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

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

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

hospitals.

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

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

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

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

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

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

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

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

only with respect to its property located in Illinois.

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

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

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

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

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

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

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

(4) Support for State health care programs for low-income individuals. At the election of the hospital applicant for each applicable year, either (A) 10% of payments to the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) under Medicaid or other means-tested programs, including, but not limited to, General Assistance~~, the Covering ALL KIDS Health Insurance Act, and the State Children's Health Insurance Program~~ or (B) the amount of subsidy provided by the relevant hospital entity and any hospital affiliate designated by the relevant hospital entity (provided that such hospital affiliate's operations provide financial or operational support for or receive financial or operational support from the relevant hospital entity) to State or local government in treating Medicaid recipients and recipients of means-tested programs, including but not limited to General Assistance~~, the Covering ALL KIDS Health Insurance~~

~~Act, and the State Children's Health Insurance Program~~. The amount of subsidy for purposes of this item (4) is calculated in the same manner as unreimbursed costs are calculated for Medicaid and other means-tested government programs in the Schedule H of IRS Form 990 in effect on the effective date of this amendatory Act of the 97th General Assembly; provided, however, that in any event unreimbursed costs shall be net of fee-for-services payments, payments pursuant to an assessment, quarterly payments, and all other payments included on the schedule H of the IRS form 990.

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

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

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

(7) Any other activity by the relevant hospital entity

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

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

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

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

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

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

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

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

(C) the applicable tax rate.

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

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

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

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

(3) The assessment factor, State equalization rate,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(110 ILCS 948/10)

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

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

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

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

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

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

"Department" means the Department of Public Health.

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

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

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

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

(110 ILCS 948/25)

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

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

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

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

(4) He or she must currently be repaying educational

loans.

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

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

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

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

(110 ILCS 948/30)

Sec. 30. The award of grants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 352. Scope of Article.

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

(b) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5-1.5)

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

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

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

Any individual determined eligible for medical assistance under this Code 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. This paragraph 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. Nothing shall prevent the Department from determining and properly establishing an individual's eligibility under a different category of eligibility.

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

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

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

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

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

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

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

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

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

(b) (Blank).

3. (Blank).

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

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

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

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

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

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

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

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

7. (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to 26 U.S.C. 220;

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

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

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

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

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

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

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

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

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

may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

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

(b) Eligibility shall be reviewed annually.

(c) (Blank).

(d) (Blank).

(e) (Blank).

(f) (Blank).

(g) (Blank).

(h) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Upon receipt of federal approval of an amendment to the

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

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

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

(2) eyeglasses prescribed by a physician skilled in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

addition to treatment for addiction.

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

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

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

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

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

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

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

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

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

medical assistance program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claims that are not submitted and received in compliance

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

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

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

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

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

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

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

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

In order to promote environmental responsibility, meet the

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

authorization conditions on enrollees of managed care organizations.

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

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

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

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

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

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

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

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

The period covered by each report shall be the 3 years

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

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

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

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

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

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

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

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

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

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

dentist and employed by a federally qualified health center. (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; revised 9-18-19.)

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

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

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

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

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

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

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

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

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

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

(3) Payment for such coordinated care shall be based

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For purposes of this subsection, "business associate",

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

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

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

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

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

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

by a qualified interpreter).

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

(4) Data tracking that identifies the language need.

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

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

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

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

6-4-18.)

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

Sec. 5A-8. Hospital Provider Fund.

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

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

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

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

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

Quality Improvement Transfer Program Act.

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

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

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

General Revenue Fund ..... $80,000,000.

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

(7.1) (Blank).

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

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

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

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

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

law until State fiscal year 2015.

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

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

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

(7.11) (Blank).

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

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

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

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

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

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

Health and Human Services Medicaid Trust Fund $10,000,000

Long-Term Care Provider Fund $15,000,000

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

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

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

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

(d) (Blank).

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

(305 ILCS 5/5G-35)

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

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

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

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

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

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

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

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

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

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

(c) The Fund shall consist of the following:

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

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

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

Department that are attributable to moneys deposited in the Fund.

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

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

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

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

(305 ILCS 5/5H-1)

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

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

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

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

"Fund" means the Healthcare Provider Relief Fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 11-22b. Recoveries.

(a) As used in this Section:

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

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

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

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

(2) The Department may:

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

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

the heirs of the deceased.

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

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

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

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

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

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

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

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

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

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

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

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

provided in subsection (c)(4).

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

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

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

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

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

same limitations as in Section 11-22 of this Code.
(Source: P.A. 94-693, eff. 7-1-06; 94-816, eff. 5-30-06; 95-755, eff. 7-25-08.)

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

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

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

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

Department may by intervention or otherwise without the necessity of assignment of claim, attach a lien on the recovery of back wages equal to the amount of assistance provided by the Department to the recipient under Article IV or Article VI~~, under the Covering ALL KIDS Health Insurance Act,~~ or under the Veterans' Health Insurance Program Act or the Veterans' Health Insurance Program Act of 2008.
(Source: P.A. 94-693, eff. 7-1-06; 94-816, eff. 5-30-06; 95-755, eff. 7-25-08.)

(305 ILCS 5/12-4.35)

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

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

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

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

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

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

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

(d) (Blank).

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

(305 ILCS 5/12-4.45)

Sec. 12-4.45. Third party liability.

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

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

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

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

(4) The effective dates of coverage for each covered

person.

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

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

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

(2) The economic harm caused by the violation.

(3) The history of previous violations.

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

(5) Efforts to correct the violation.

(6) Any other matter that justice may require.

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

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

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

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

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

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

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

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

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

The balance in this Fund after payment therefrom of any amounts reimbursable to the federal government, and minus the amount reasonably anticipated to be needed to make the disbursements authorized by this Section during the current and following 3 calendar months, shall be certified by the Director of Healthcare and Family Services and transferred by the State Comptroller to the Drug Rebate Fund or the Healthcare Provider Relief Fund in the State Treasury, as

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

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

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

(305 ILCS 5/12-10.4)

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

condition of their aftercare release.

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

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

(305 ILCS 5/5-29 rep.)

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

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

(325 ILCS 20/13.5)

Sec. 13.5. Other programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

(330 ILCS 126/15)

Sec. 15. Eligibility.

(a) To be eligible for the Program, a person must:

(1) be a veteran who is not on active duty and who has not been dishonorably discharged from service or the spouse of such a veteran;

(2) be a resident of the State of Illinois;

(3) be at least 19 years of age and no older than 64

years of age;

(4) be uninsured, as defined by the Department by rule, for a period of time established by the Department by rule, which shall be no less than 3 months;

(5) not be eligible for medical assistance under the Illinois Public Aid Code ~~or healthcare benefits under the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act~~;

(6) not be eligible for medical benefits through the Veterans Health Administration; and

(7) have a household income no greater than the sum of (i) an amount equal to 25% of the federal poverty level plus (ii) an amount equal to the Veterans Administration means test income threshold at the initiation of the Program; depending on the availability of funds, this level may be increased to an amount equal to the sum of (iii) an amount equal to 50% of the federal poverty level plus (iv) an amount equal to the Veterans Administration means test income threshold. This means test income threshold is subject to alteration by the Department as set forth in subsection (b) of Section 10.

(b) A veteran or spouse who is determined eligible for the Program shall remain eligible for 12 months, provided the veteran or spouse remains a resident of the State and is not excluded under subsection (c) of this Section and provided the Department has not limited the enrollment period as set forth

in subsection (b) of Section 10.

(c) A veteran or spouse is not eligible for coverage under the Program if:

(1) the premium required under Section 35 of this Act has not been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid and for grace periods as established under subsection (d); if the required monthly premium is not paid, the veteran or spouse is ineligible for re-enrollment for a minimum period of 3 months; or

(2) the veteran or spouse is a resident of a nursing facility or an inmate of a public institution, as defined by 42 CFR 435.1009.

(d) The Department shall adopt rules for the Program, including, but not limited to, rules relating to eligibility, re-enrollment, grace periods, notice requirements, hearing procedures, cost-sharing, covered services, and provider requirements.

(Source: P.A. 95-755, eff. 7-25-08; 96-45, eff. 7-15-09.)

(215 ILCS 106/Act rep.)

Section 75. The Children's Health Insurance Program Act is repealed.

(215 ILCS 170/Act rep.)

Section 80. The Covering ALL KIDS Health Insurance Act is repealed.

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Statutes amended in order of appearance

305 ILCS 5/11-22b	from Ch. 23, par. 11-22b
305 ILCS 5/11-22c	from Ch. 23, par. 11-22c
305 ILCS 5/12-4.35	
305 ILCS 5/12-4.45	
305 ILCS 5/12-9	from Ch. 23, par. 12-9
305 ILCS 5/12-10.4	
305 ILCS 5/5-29 rep.	
325 ILCS 20/13.5	
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215 ILCS 170/Act rep.	