



Rep. Sara Feigenholtz

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1 AMENDMENT TO SENATE BILL 2840

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

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

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

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

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

4 Sec. 5-45. Emergency rulemaking.

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

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

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

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

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

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

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

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

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

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

1 subsection (h). The adoption of emergency rules authorized by
2 this subsection (h) shall be deemed to be necessary for the
3 public interest, safety, and welfare.

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

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

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

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

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

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

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

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

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

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

25 (p) In order to provide for the expeditious and timely
26 implementation of the provisions of this amendatory Act of the

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

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

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

17 (20 ILCS 415/4d) (from Ch. 127, par. 63b104d)

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

22 (1) In each department, board or commission that now
23 maintains or may hereafter maintain a major administrative
24 division, service or office in both Sangamon County and

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

14 (2) The resident administrative head of each State
15 charitable, penal and correctional institution, the
16 chaplains thereof, and all member, patient and inmate
17 employees are exempt from jurisdiction B.

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

1 requirements, and except positions in agencies supported
2 in whole by federal funds.

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

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

24 (6) All positions established outside the geographical
25 limits of the State of Illinois to which appointments of
26 other than Illinois citizens may be made are exempt from

1 jurisdiction B.

2 (7) Staff attorneys reporting directly to individual
3 Commissioners of the Illinois Workers' Compensation
4 Commission are exempt from jurisdiction B.

5 (8) Twenty-one ~~Twenty~~ senior public service
6 administrator positions within the Department of
7 Healthcare and Family Services, as set forth in this
8 paragraph (8), requiring the specific knowledge of
9 healthcare administration, healthcare finance, healthcare
10 data analytics, or information technology described are
11 exempt from jurisdiction B only to the extent that the
12 requirements of Sections 8b.1, 8b.3, and 8b.5 of this Code
13 need not be met. The General Assembly finds that these
14 positions are all senior policy makers and have
15 spokesperson authority for the Director of the Department
16 of Healthcare and Family Services. When filling positions
17 so designated, the Director of Healthcare and Family
18 Services shall cause a position description to be published
19 which allots points to various qualifications desired.
20 After scoring qualified applications, the Director shall
21 add Veteran's Preference points as enumerated in Section
22 8b.7 of this Code. The following are the minimum
23 qualifications for the senior public service administrator
24 positions provided for in this paragraph (8):

25 (A) HEALTHCARE ADMINISTRATION.

26 Medical Director: Licensed Medical Doctor in

1 good standing; experience in healthcare payment
2 systems, pay for performance initiatives, medical
3 necessity criteria or federal or State quality
4 improvement programs; preferred experience serving
5 Medicaid patients or experience in population
6 health programs with a large provider, health
7 insurer, government agency, or research
8 institution.

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

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

20 Quality Management Bureau: Manager, Primary
21 Care Provider Quality and Practice Development:
22 Clinical degree or advanced degree in relevant
23 field required; experience in practice
24 administration in the primary care setting with a
25 provider or a provider association or an
26 accrediting body; knowledge of practice standards

1 for medical homes and best evidence based
2 standards of care for primary care.

3 Director of Care Coordination Contracts and
4 Compliance: Bachelor's degree required; multi-year
5 experience in negotiating managed care contracts,
6 preferably on behalf of a payer; experience with
7 health care contract compliance.

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

20 Manager, Behavioral Health Programs: Clinical
21 license or Advanced degree required, preferably in
22 psychology, social work, or relevant field;
23 knowledge of medical necessity criteria and
24 governmental policies and regulations governing
25 the provision of mental health services to
26 Medicaid populations, including children and

1 adults, in community and institutional settings of
2 care. The General Assembly finds that this
3 position is necessary for the timely and effective
4 implementation of this amendatory Act of the 97th
5 General Assembly.

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

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

24 Director of Dental Program: Bachelor's degree
25 required, advanced degree preferred, in healthcare
26 management or relevant field; experience in

1 healthcare administration; experience in
2 administering dental healthcare programs,
3 knowledge of practice standards for dental care
4 and treatment services; knowledge of the public
5 dental health infrastructure.

6 Manager of Medicare/Medicaid Coordination:
7 Bachelor's degree required, knowledge and
8 experience with Medicare Advantage rules and
9 regulations, knowledge of Medicaid laws and
10 policies; experience with contract drafting
11 preferred.

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

24 (B) HEALTHCARE FINANCE.

25 Director of Care Coordination Rate and
26 Finance: MBA, CPA, or Actuarial degree required;

1 experience in managed care rate setting,
2 including, but not limited to, baseline costs and
3 growth trends; knowledge and experience with
4 Medical Loss Ratio standards and measurements.

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

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

22 Manager of Medical Finance, Division of
23 Finance: Requires relevant advanced degree or
24 certification in relevant field, such as Certified
25 Public Accountant; coursework in business or
26 public administration, accounting, finance, data

1 analysis, or statistics preferred; experience in
2 control systems and GAAP; financial management
3 experience in a healthcare or government entity
4 utilizing Medicaid funding.

5 (C) HEALTHCARE DATA ANALYTICS.

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

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

1 Data Analytics Platform Manager: Bachelor's
2 degree required, advanced degree preferred,
3 preferably in business or information systems;
4 extensive healthcare data reporting experience
5 with a large provider, health insurer, government
6 agency, or research institution; previous
7 experience working on a health insurance data
8 analytics platform; experience managing contracts
9 and vendors preferred.

10 (D) HEALTHCARE INFORMATION TECHNOLOGY.

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

17 Manager of MMIS Claims Unit: Bachelor's degree
18 required, with preferred coursework in business,
19 public administration, information systems;
20 experience equivalent to 4 years of administration
21 in a public or business organization; working
22 knowledge with design and implementation of
23 technical solutions to medical claims payment
24 systems; extensive technical writing experience,
25 including, but not limited to, the development of
26 RFPs, APDs, feasibility studies, and related

1 documents; thorough knowledge of IT system design,
2 commercial off the shelf software packages and
3 hardware components.

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

20 Technical System Architect: Bachelor's degree
21 required, with preferred coursework in computer
22 science or information technology; prior
23 experience equivalent to 5 years of computer
24 science or IT administration in a public or
25 business organization; extensive healthcare
26 technology experience with a large provider,

1 health insurer, government agency, or research
2 institution; experience as a business analyst
3 interfacing between business and information
4 technology departments.

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

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

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

10 (30 ILCS 5/2-20 new)

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

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

21 (b) No later than March 1, 2013, the Department shall
22 provide evidence to the Auditor General that it has undertaken
23 the required actions listed in the report required by
24 subsection (a).

1 (c) No later than May 1, 2013, the Auditor General shall
2 submit a report to the Governor, the Speaker of the House of
3 Representatives, the Minority Leader of the House of
4 Representatives, the Senate President, and the Senate Minority
5 Leader as to whether the Department has undertaken the required
6 actions listed in the report required by subsection (a).

7 Section 15. The State Finance Act is amended by changing
8 Sections 6z-52 and 13.2 as follows:

9 (30 ILCS 105/6z-52)

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

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

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

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

1 (2) For reimbursement of moneys collected by the
2 Department of Healthcare and Family Services (formerly
3 Illinois Department of Public Aid) through error or
4 mistake.

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

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

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

18 (1) Upon notification from the Director of Healthcare
19 and Family Services, the Comptroller shall direct and the
20 Treasurer shall transfer the net State share (disregarding
21 the reduction in net State share attributable to the
22 American Recovery and Reinvestment Act of 2009 or any other
23 federal economic stimulus program) of all moneys received
24 by the Department of Healthcare and Family Services
25 (formerly Illinois Department of Public Aid) from drug
26 rebate agreements with pharmaceutical manufacturers

1 pursuant to Title XIX of the federal Social Security Act,
2 including any portion of the balance in the Public Aid
3 Recoveries Trust Fund on July 1, 2001 that is attributable
4 to such receipts.

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

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

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

15 (Source: P.A. 95-331, eff. 8-21-07; 96-8, eff. 4-28-09;
16 96-1100, eff. 1-1-11.)

17 (30 ILCS 105/13.2) (from Ch. 127, par. 149.2)

18 Sec. 13.2. Transfers among line item appropriations.

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

25 (a-1) No transfers may be made from one agency to another

1 agency, nor may transfers be made from one institution of
2 higher education to another institution of higher education
3 except as provided by subsection (a-4).

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

1 2010, the Department of Transportation may transfer amounts
2 among their respective appropriations within the same treasury
3 fund for personal services, employee retirement contributions
4 paid by employer, and State contributions to retirement
5 systems. During State fiscal year 2010 only, an agency may
6 transfer amounts among its respective appropriations within
7 the same treasury fund for personal services, employee
8 retirement contributions paid by employer, and State
9 contributions to retirement systems. Notwithstanding, and in
10 addition to, the transfers authorized in subsection (c) of this
11 Section, these transfers may be made in an amount not to exceed
12 2% of the aggregate amount appropriated to an agency within the
13 same treasury fund.

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

22 (a-4) Long-Term Care Rebalancing. The Governor may
23 designate amounts set aside for institutional services
24 appropriated from the General Revenue Fund or any other State
25 fund that receives monies for long-term care services to be
26 transferred to all State agencies responsible for the

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

21 (b) In addition to the general transfer authority provided
22 under subsection (c), the following agencies have the specific
23 transfer authority granted in this subsection:

24 The Department of Healthcare and Family Services is
25 authorized to make transfers representing savings attributable
26 to not increasing grants due to the births of additional

1 children from line items for payments of cash grants to line
2 items for payments for employment and social services for the
3 purposes outlined in subsection (f) of Section 4-2 of the
4 Illinois Public Aid Code.

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

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

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

26 The State Board of Education is authorized to make

1 transfers from line item appropriations within the same
2 treasury fund for General State Aid and General State Aid -
3 Hold Harmless, provided that no such transfer may be made
4 unless the amount transferred is no longer required for the
5 purpose for which that appropriation was made, to the line item
6 appropriation for Transitional Assistance when the balance
7 remaining in such line item appropriation is insufficient for
8 the purpose for which the appropriation was made.

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

26 ~~The During State fiscal years 2010 and 2011 only, the~~

1 Department of Healthcare and Family Services is authorized to
2 make transfers not exceeding 4% of the aggregate amount
3 appropriated to it, within the same treasury fund, among the
4 various line items appropriated for Medical Assistance.

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

26 (c-1) Special provisions for State fiscal year 2003.

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

21 (c-2) Special provisions for State fiscal year 2005.
22 Notwithstanding subsections (a), (a-2), and (c), for State
23 fiscal year 2005 only, transfers may be made among any line
24 item appropriations from the same or any other treasury fund
25 for any objects or purposes, without limitation, when the
26 balance remaining in one or more such line item appropriations

1 is insufficient for the purpose for which the appropriation was
2 made, provided that the sum of those transfers by a State
3 agency shall not exceed 4% of the aggregate amount appropriated
4 to that State agency for fiscal year 2005.

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

19 The officer responsible for approval shall certify that the
20 transfer is necessary to carry out the programs and purposes
21 for which the appropriations were made by the General Assembly
22 and shall transmit to the State Comptroller a certified copy of
23 the approval which shall set forth the specific amounts
24 transferred so that the Comptroller may change his records
25 accordingly. The Comptroller shall furnish the Governor with
26 information copies of all transfers approved for agencies of

1 the Legislative and Judicial departments and transfers
2 approved by the constitutionally elected officials of the
3 Executive branch other than the Governor, showing the amounts
4 transferred and indicating the dates such changes were entered
5 on the Comptroller's records.

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

15 (1) Disabled Student Personnel Reimbursement (Section
16 14-13.01 of the School Code);

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

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

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

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

24 (6) Summer School Payments (Section 18-4.3 of the
25 School Code);

26 (7) Transportation - Regular/Vocational Reimbursement

1 (Section 29-5 of the School Code);

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

4 (9) Special Education Reimbursement (Section 14-7.03
5 of the School Code).

6 (Source: P.A. 95-707, eff. 1-11-08; 96-37, eff. 7-13-09;
7 96-820, eff. 11-18-09; 96-959, eff. 7-1-10; 96-1086, eff.
8 7-16-10; 96-1501, eff. 1-25-11.)

9 (30 ILCS 105/5.441 rep.)

10 (30 ILCS 105/5.442 rep.)

11 (30 ILCS 105/5.549 rep.)

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

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

16 (30 ILCS 500/1-10)

17 Sec. 1-10. Application.

18 (a) This Code applies only to procurements for which
19 contractors were first solicited on or after July 1, 1998. This
20 Code shall not be construed to affect or impair any contract,
21 or any provision of a contract, entered into based on a
22 solicitation prior to the implementation date of this Code as
23 described in Article 99, including but not limited to any

1 covenant entered into with respect to any revenue bonds or
2 similar instruments. All procurements for which contracts are
3 solicited between the effective date of Articles 50 and 99 and
4 July 1, 1998 shall be substantially in accordance with this
5 Code and its intent.

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

9 (1) Contracts between the State and its political
10 subdivisions or other governments, or between State
11 governmental bodies except as specifically provided in
12 this Code.

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

15 (3) Purchase of care.

16 (4) Hiring of an individual as employee and not as an
17 independent contractor, whether pursuant to an employment
18 code or policy or by contract directly with that
19 individual.

20 (5) Collective bargaining contracts.

21 (6) Purchase of real estate, except that notice of this
22 type of contract with a value of more than \$25,000 must be
23 published in the Procurement Bulletin within 7 days after
24 the deed is recorded in the county of jurisdiction. The
25 notice shall identify the real estate purchased, the names
26 of all parties to the contract, the value of the contract,

1 and the effective date of the contract.

2 (7) Contracts necessary to prepare for anticipated
3 litigation, enforcement actions, or investigations,
4 provided that the chief legal counsel to the Governor shall
5 give his or her prior approval when the procuring agency is
6 one subject to the jurisdiction of the Governor, and
7 provided that the chief legal counsel of any other
8 procuring entity subject to this Code shall give his or her
9 prior approval when the procuring entity is not one subject
10 to the jurisdiction of the Governor.

11 (8) Contracts for services to Northern Illinois
12 University by a person, acting as an independent
13 contractor, who is qualified by education, experience, and
14 technical ability and is selected by negotiation for the
15 purpose of providing non-credit educational service
16 activities or products by means of specialized programs
17 offered by the university.

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

20 (10) Procurement expenditures by the Illinois Health
21 Information Exchange Authority involving private funds
22 from the Health Information Exchange Fund. "Private funds"
23 means gifts, donations, and private grants.

24 (11) Public-private agreements entered into according
25 to the procurement requirements of Section 20 of the
26 Public-Private Partnerships for Transportation Act and

1 design-build agreements entered into according to the
2 procurement requirements of Section 25 of the
3 Public-Private Partnerships for Transportation Act.

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

8 (d) Except for Section 20-160 and Article 50 of this Code,
9 and as expressly required by Section 9.1 of the Illinois
10 Lottery Law, the provisions of this Code do not apply to the
11 procurement process provided for under Section 9.1 of the
12 Illinois Lottery Law.

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

24 (f) This Code does not apply to the process used by the
25 Illinois Power Agency to retain a mediator to mediate sourcing
26 agreement disputes between gas utilities and the clean coal SNG

1 brownfield facility, as defined in Section 1-10 of the Illinois
2 Power Agency Act, as required under subsection (h-1) of Section
3 9-220 of the Public Utilities Act.

4 (g) ~~(e)~~ This Code does not apply to the processes used by
5 the Illinois Power Agency to retain a mediator to mediate
6 contract disputes between gas utilities and the clean coal SNG
7 facility and to retain an expert to assist in the review of
8 contracts under subsection (h) of Section 9-220 of the Public
9 Utilities Act. This Code does not apply to the process used by
10 the Illinois Commerce Commission to retain an expert to assist
11 in determining the actual incurred costs of the clean coal SNG
12 facility and the reasonableness of those costs as required
13 under subsection (h) of Section 9-220 of the Public Utilities
14 Act.

15 (h) This Code does not apply to the process to procure or
16 contracts entered into in accordance with Sections 11-5.2 and
17 11-5.3 of the Illinois Public Aid Code.

18 (Source: P.A. 96-840, eff. 12-23-09; 96-1331, eff. 7-27-10;
19 97-96, eff. 7-13-11; 97-239, eff. 8-2-11; 97-502, eff. 8-23-11;
20 revised 9-7-11.)

21 (30 ILCS 775/Act rep.)

22 Section 30. The Excellence in Academic Medicine Act is
23 repealed.

24 Section 45. The Nursing Home Care Act is amended by

1 changing Section 3-202.05 as follows:

2 (210 ILCS 45/3-202.05)

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

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

- 7 (1) registered nurses;
- 8 (2) licensed practical nurses;
- 9 (3) certified nurse assistants;
- 10 (4) psychiatric services rehabilitation aides;
- 11 (5) rehabilitation and therapy aides;
- 12 (6) psychiatric services rehabilitation coordinators;
- 13 (7) assistant directors of nursing;
- 14 (8) 50% of the Director of Nurses' time; and
- 15 (9) 30% of the Social Services Directors' time.

16 The Department shall, by rule, allow certain facilities
17 subject to 77 Ill. Admin. Code 300.4000 and following (Subpart
18 S) ~~and 300.6000 and following (Subpart T)~~ to utilize
19 specialized clinical staff, as defined in rules, to count
20 towards the staffing ratios.

21 Within 120 days of the effective date of this amendatory
22 Act of the 97th General Assembly, the Department shall
23 promulgate rules specific to the staffing requirements for
24 facilities federally defined as Institutions for Mental
25 Disease. These rules shall recognize the unique nature of

1 individuals with chronic mental health conditions, shall
2 include minimum requirements for specialized clinical staff,
3 including clinical social workers, psychiatrists,
4 psychologists, and direct care staff set forth in paragraphs
5 (4) through (6) and any other specialized staff which may be
6 utilized and deemed necessary to count toward staffing ratios.

7 Within 120 days of the effective date of this amendatory
8 Act of the 97th General Assembly, the Department shall
9 promulgate rules specific to the staffing requirements for
10 facilities licensed under the Specialized Mental Health
11 Rehabilitation Act. These rules shall recognize the unique
12 nature of individuals with chronic mental health conditions,
13 shall include minimum requirements for specialized clinical
14 staff, including clinical social workers, psychiatrists,
15 psychologists, and direct care staff set forth in paragraphs
16 (4) through (6) and any other specialized staff which may be
17 utilized and deemed necessary to count toward staffing ratios.

18 (b) Beginning January 1, 2011, and thereafter, light
19 intermediate care shall be staffed at the same staffing ratio
20 as intermediate care.

21 (c) Facilities shall notify the Department within 60 days
22 after the effective date of this amendatory Act of the 96th
23 General Assembly, in a form and manner prescribed by the
24 Department, of the staffing ratios in effect on the effective
25 date of this amendatory Act of the 96th General Assembly for
26 both intermediate and skilled care and the number of residents

1 receiving each level of care.

2 (d) (1) Effective July 1, 2010, for each resident needing
3 skilled care, a minimum staffing ratio of 2.5 hours of nursing
4 and personal care each day must be provided; for each resident
5 needing intermediate care, 1.7 hours of nursing and personal
6 care each day must be provided.

7 (2) Effective January 1, 2011, the minimum staffing ratios
8 shall be increased to 2.7 hours of nursing and personal care
9 each day for a resident needing skilled care and 1.9 hours of
10 nursing and personal care each day for a resident needing
11 intermediate care.

12 (3) Effective January 1, 2012, the minimum staffing ratios
13 shall be increased to 3.0 hours of nursing and personal care
14 each day for a resident needing skilled care and 2.1 hours of
15 nursing and personal care each day for a resident needing
16 intermediate care.

17 (4) Effective January 1, 2013, the minimum staffing ratios
18 shall be increased to 3.4 hours of nursing and personal care
19 each day for a resident needing skilled care and 2.3 hours of
20 nursing and personal care each day for a resident needing
21 intermediate care.

22 (5) Effective January 1, 2014, the minimum staffing ratios
23 shall be increased to 3.8 hours of nursing and personal care
24 each day for a resident needing skilled care and 2.5 hours of
25 nursing and personal care each day for a resident needing
26 intermediate care.

1 (e) Ninety days after the effective date of this amendatory
2 Act of the 97th General Assembly, a minimum of 25% of nursing
3 and personal care time shall be provided by licensed nurses,
4 with at least 10% of nursing and personal care time provided by
5 registered nurses. These minimum requirements shall remain in
6 effect until an acuity based registered nurse requirement is
7 promulgated by rule concurrent with the adoption of the
8 Resource Utilization Group classification-based payment
9 methodology, as provided in Section 5-5.2 of the Illinois
10 Public Aid Code. Registered nurses and licensed practical
11 nurses employed by a facility in excess of these requirements
12 may be used to satisfy the remaining 75% of the nursing and
13 personal care time requirements. Notwithstanding this
14 subsection, no staffing requirement in statute in effect on the
15 effective date of this amendatory Act of the 97th General
16 Assembly shall be reduced on account of this subsection.

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

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

20 (210 ILCS 50/3.86)

21 Sec. 3.86. Stretcher van providers.

22 (a) In this Section, "stretcher van provider" means an
23 entity licensed by the Department to provide non-emergency
24 transportation of passengers on a stretcher in compliance with

1 this Act or the rules adopted by the Department pursuant to
2 this Act, utilizing stretcher vans.

3 (b) The Department has the authority and responsibility to
4 do the following:

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

7 (2) Establish licensing and safety standards and
8 requirements for stretcher van providers, through rules
9 adopted pursuant to this Act, including but not limited to:

10 (A) Vehicle design, specification, operation, and
11 maintenance standards.

12 (B) Safety equipment requirements and standards.

13 (C) Staffing requirements.

14 (D) Annual license renewal.

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

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

20 (5) Suspend, revoke, refuse to issue, or refuse to
21 renew the license of any stretcher van provider, or that
22 portion of a license pertaining to a specific vehicle
23 operated by a provider, after an opportunity for a hearing,
24 when findings show that the provider or one or more of its
25 vehicles has failed to comply with the standards and
26 requirements of this Act or the rules adopted by the

1 Department pursuant to this Act.

2 (6) Issue an emergency suspension order for any
3 provider or vehicle licensed under this Act when the
4 Director or his or her designee has determined that an
5 immediate or serious danger to the public health, safety,
6 and welfare exists. Suspension or revocation proceedings
7 that offer an opportunity for a hearing shall be promptly
8 initiated after the emergency suspension order has been
9 issued.

10 (7) Prohibit any stretcher van provider from
11 advertising, identifying its vehicles, or disseminating
12 information in a false or misleading manner concerning the
13 provider's type and level of vehicles, location, response
14 times, level of personnel, licensure status, or EMS System
15 participation.

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

19 (c) A stretcher van provider may provide transport of a
20 passenger on a stretcher, provided the passenger meets all of
21 the following requirements:

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

24 (2) He or she needs no medical monitoring or clinical
25 observation ~~medical observation.~~

26 (3) He or she needs routine transportation to or from a

1 medical appointment or service if the passenger is
2 convalescent or otherwise bed-confined and does not
3 require clinical observation ~~medical monitoring~~, aid,
4 care, or treatment during transport.

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

7 (1) He or she is being transported to a hospital for
8 emergency medical treatment. ~~He or she is currently~~
9 ~~admitted to a hospital or is being transported to a~~
10 ~~hospital for admission or emergency treatment.~~

11 (2) He or she is experiencing an emergency medical
12 condition or needs active medical monitoring, including
13 isolation precautions, supplemental oxygen that is not
14 self-administered, continuous airway management,
15 suctioning during transport, or the administration of
16 intravenous fluids during transport. ~~He or she is acutely~~
17 ~~ill, wounded, or medically unstable as determined by a~~
18 ~~licensed physician.~~

19 ~~(3) He or she is experiencing an emergency medical~~
20 ~~condition, an acute medical condition, an exacerbation of a~~
21 ~~chronic medical condition, or a sudden illness or injury.~~

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

24 ~~(5) He or she was moved from one environment where~~
25 ~~24 hour medical monitoring or medical observation will~~
26 ~~take place by certified or licensed nursing personnel to~~

1 ~~another such environment. Such environments shall include,~~
2 ~~but not be limited to, hospitals licensed under the~~
3 ~~Hospital Licensing Act or operated under the University of~~
4 ~~Illinois Hospital Act, and nursing facilities licensed~~
5 ~~under the Nursing Home Care Act.~~

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

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

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

16 (210 ILCS 155/35)

17 Sec. 35. LTAC supplemental per diem rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (210 ILCS 155/40)

2 Sec. 40. Rate adjustments for quality measures.

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

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

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

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

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

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

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

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

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

15 (210 ILCS 155/45)

16 Sec. 45. Program evaluation.

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

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

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

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

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

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

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

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

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

9 (210 ILCS 155/55 new)

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

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

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

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

20 (215 ILCS 106/25)

21 Sec. 25. Health benefits for children.

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

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

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

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

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

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

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

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

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

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

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

20 (215 ILCS 106/40)

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

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

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

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

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

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

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

4 (215 ILCS 170/30)

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

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

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

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

17 (215 ILCS 170/35)

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

19 Sec. 35. Health care benefits for children.

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

1 transportation.

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

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

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

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

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

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

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

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

14 (305 ILCS 5/3-1.2) (from Ch. 23, par. 3-1.2)

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

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

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

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

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

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

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

24 (2) Funds in an irrevocable prepaid funeral or burial
25 contract are exempt up to \$5,874, except that any portion
26 of a contract that clearly represents the purchase of

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

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

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

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

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

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

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

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

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

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

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

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

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

24 2. Persons otherwise eligible for basic maintenance
25 under Articles III and IV, excluding any eligibility

1 requirements that are inconsistent with any federal law or
2 federal regulation, as interpreted by the U.S. Department
3 of Health and Human Services, but who fail to qualify
4 thereunder on the basis of need or who qualify but are not
5 receiving basic maintenance under Article IV, and who have
6 insufficient income and resources to meet the costs of
7 necessary medical care, including but not limited to the
8 following:

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

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

26 (ii) their income, after the deduction of

1 costs incurred for medical care and for other types
2 of remedial care, is equal to or less than 70% in
3 fiscal year 2001, equal to or less than 85% in
4 fiscal year 2002 and until a date to be determined
5 by the Department by rule, and equal to or less
6 than 100% beginning on the date determined by the
7 Department by rule, of the nonfarm income official
8 poverty line, as defined in item (i) of this
9 subparagraph (a).

10 (b) All persons who, excluding any eligibility
11 requirements that are inconsistent with any federal
12 law or federal regulation, as interpreted by the U.S.
13 Department of Health and Human Services, would be
14 determined eligible for such basic maintenance under
15 Article IV by disregarding the maximum earned income
16 permitted by federal law.

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

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

24 5.(a) Women during pregnancy, after the fact of
25 pregnancy has been determined by medical diagnosis, and
26 during the 60-day period beginning on the last day of the

1 pregnancy, together with their infants and children born
2 after September 30, 1983, whose income and resources are
3 insufficient to meet the costs of necessary medical care to
4 the maximum extent possible under Title XIX of the Federal
5 Social Security Act.

6 (b) The Illinois Department and the Governor shall
7 provide a plan for coverage of the persons eligible under
8 paragraph 5(a) by April 1, 1990. Such plan shall provide
9 ambulatory prenatal care to pregnant women during a
10 presumptive eligibility period and establish an income
11 eligibility standard that is equal to 133% of the nonfarm
12 income official poverty line, as defined by the federal
13 Office of Management and Budget and revised annually in
14 accordance with Section 673(2) of the Omnibus Budget
15 Reconciliation Act of 1981, applicable to families of the
16 same size, provided that costs incurred for medical care
17 are not taken into account in determining such income
18 eligibility.

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

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

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

10 7. (Blank). ~~Persons who are under 21 years of age and~~
11 ~~would qualify as disabled as defined under the Federal~~
12 ~~Supplemental Security Income Program, provided medical~~
13 ~~service for such persons would be eligible for Federal~~
14 ~~Financial Participation, and provided the Illinois~~
15 ~~Department determines that:~~

16 ~~(a) the person requires a level of care provided by~~
17 ~~a hospital, skilled nursing facility, or intermediate~~
18 ~~care facility, as determined by a physician licensed to~~
19 ~~practice medicine in all its branches;~~

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

23 ~~(c) the estimated amount which would be expended~~
24 ~~for care outside the institution is not greater than~~
25 ~~the estimated amount which would be expended in an~~
26 ~~institution.~~

1 8. Persons who become ineligible for basic maintenance
2 assistance under Article IV of this Code in programs
3 administered by the Illinois Department due to employment
4 earnings and persons in assistance units comprised of
5 adults and children who become ineligible for basic
6 maintenance assistance under Article VI of this Code due to
7 employment earnings. The plan for coverage for this class
8 of persons shall:

9 (a) extend the medical assistance coverage for up
10 to 12 months following termination of basic
11 maintenance assistance; and

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

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

18 (ii) such coverage shall include all services
19 covered while the person was eligible for basic
20 maintenance assistance;

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

23 (iv) such coverage shall be suspended in the
24 event of a person's failure without good cause to
25 file in a timely fashion reports required for this
26 coverage under the Social Security Act and

1 coverage shall be reinstated upon the filing of
2 such reports if the person remains otherwise
3 eligible.

4 9. Persons with acquired immunodeficiency syndrome
5 (AIDS) or with AIDS-related conditions with respect to whom
6 there has been a determination that but for home or
7 community-based services such individuals would require
8 the level of care provided in an inpatient hospital,
9 skilled nursing facility or intermediate care facility the
10 cost of which is reimbursed under this Article. Assistance
11 shall be provided to such persons to the maximum extent
12 permitted under Title XIX of the Federal Social Security
13 Act.

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

19 11. Persons with disabilities who are employed and
20 eligible for Medicaid, pursuant to Section
21 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,
22 subject to federal approval, persons with a medically
23 improved disability who are employed and eligible for
24 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
25 the Social Security Act, as provided by the Illinois
26 Department by rule. In establishing eligibility standards

1 under this paragraph 11, the Department shall, subject to
2 federal approval:

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

5 (b) exempt retirement accounts that the person
6 cannot access without penalty before the age of 59 1/2,
7 and medical savings accounts established pursuant to
8 26 U.S.C. 220;

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

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

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

22 (1) persons who have been screened for breast or
23 cervical cancer under the U.S. Centers for Disease
24 Control and Prevention Breast and Cervical Cancer
25 Program established under Title XV of the federal
26 Public Health Services Act in accordance with the

1 requirements of Section 1504 of that Act as
2 administered by the Illinois Department of Public
3 Health; and

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

8 "Medical assistance" under this paragraph 12 shall be
9 identical to the benefits provided under the State's
10 approved plan under Title XIX of the Social Security Act.
11 The Department must request federal approval of the
12 coverage under this paragraph 12 within 30 days after the
13 effective date of this amendatory Act of the 92nd General
14 Assembly.

15 In addition to the persons who are eligible for medical
16 assistance pursuant to subparagraphs (1) and (2) of this
17 paragraph 12, and to be paid from funds appropriated to the
18 Department for its medical programs, any uninsured person
19 as defined by the Department in rules residing in Illinois
20 who is younger than 65 years of age, who has been screened
21 for breast and cervical cancer in accordance with standards
22 and procedures adopted by the Department of Public Health
23 for screening, and who is referred to the Department by the
24 Department of Public Health as being in need of treatment
25 for breast or cervical cancer is eligible for medical
26 assistance benefits that are consistent with the benefits

1 provided to those persons described in subparagraphs (1)
2 and (2). Medical assistance coverage for the persons who
3 are eligible under the preceding sentence is not dependent
4 on federal approval, but federal moneys may be used to pay
5 for services provided under that coverage upon federal
6 approval.

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

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

1 long as an individual continues to satisfy the criteria of
2 this paragraph 14. If an individual has an appeal pending
3 regarding an application for asylum before the Department
4 of Homeland Security, eligibility under this paragraph 14
5 may be extended until a final decision is rendered on the
6 appeal. The Department may adopt rules governing the
7 implementation of this paragraph 14.

8 15. Family Care Eligibility.

9 (a) On and after July 1, 2012 ~~Through December 31,~~
10 ~~2013,~~ a caretaker relative who is 19 years of age or
11 older when countable income is at or below 133% ~~185%~~ of
12 the Federal Poverty Level Guidelines, as published
13 annually in the Federal Register, for the appropriate
14 family size. ~~Beginning January 1, 2014, a caretaker~~
15 ~~relative who is 19 years of age or older when countable~~
16 ~~income is at or below 133% of the Federal Poverty Level~~
17 ~~Guidelines, as published annually in the Federal~~
18 ~~Register, for the appropriate family size.~~ A person may
19 not spend down to become eligible under this paragraph
20 15.

21 (b) Eligibility shall be reviewed annually.

22 (c) (Blank). ~~Caretaker relatives enrolled under~~
23 ~~this paragraph 15 in families with countable income~~
24 ~~above 150% and at or below 185% of the Federal Poverty~~
25 ~~Level Guidelines shall be counted as family members and~~
26 ~~pay premiums as established under the Children's~~

1 ~~Health Insurance Program Act.~~

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

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

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

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

12 (h) (Blank). ~~Partial premium payments shall not be~~
13 ~~refunded.~~

14 (i) Following termination of an individual's
15 coverage under this paragraph 15, the individual must
16 be determined eligible before the person can be
17 re-enrolled. ~~following action is required before the~~
18 ~~individual can be re-enrolled:~~

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

21 (2) ~~There must be full payment of premiums due~~
22 ~~under this Code, the Children's Health Insurance~~
23 ~~Program Act, the Covering ALL KIDS Health~~
24 ~~Insurance Act, or any other healthcare program~~
25 ~~administered by the Department for periods in~~
26 ~~which a premium was owed and not paid for the~~

1 ~~individual.~~

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

5 ~~The Department is authorized to implement the~~
6 ~~provisions of this amendatory Act of the 95th General~~
7 ~~Assembly by adopting the medical assistance rules in effect~~
8 ~~as of October 1, 2007, at 89 Ill. Admin. Code 125, and at~~
9 ~~89 Ill. Admin. Code 120.32 along with only those changes~~
10 ~~necessary to conform to federal Medicaid requirements,~~
11 ~~federal laws, and federal regulations, including but not~~
12 ~~limited to Section 1931 of the Social Security Act (42~~
13 ~~U.S.C. Sec. 1396u-1), as interpreted by the U.S. Department~~
14 ~~of Health and Human Services, and the countable income~~
15 ~~eligibility standard authorized by this paragraph 15. The~~
16 ~~Department may not otherwise adopt any rule to implement~~
17 ~~this increase except as authorized by law, to meet the~~
18 ~~eligibility standards authorized by the federal government~~
19 ~~in the Medicaid State Plan or the Title XXI Plan, or to~~
20 ~~meet an order from the federal government or any court.~~

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

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

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

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

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

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

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

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

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

15 (Source: P.A. 96-20, eff. 6-30-09; 96-181, eff. 8-10-09;
16 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff.
17 7-2-10; 96-1123, eff. 1-1-11; 96-1270, eff. 7-26-10; 97-48,
18 eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11;
19 revised 10-4-11.)

20 (305 ILCS 5/5-2b new)

21 Sec. 5-2b. Medically fragile and technology dependent
22 children eligibility and program. Notwithstanding any other
23 provision of law, on and after September 1, 2012, subject to
24 federal approval, medical assistance under this Article shall
25 be available to children who qualify as persons with a

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

14 (305 ILCS 5/5-2.1d new)

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

1 (305 ILCS 5/5-4) (from Ch. 23, par. 5-4)

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

3 (a) The amount and nature of medical assistance shall be
4 determined ~~by the County Departments~~ in accordance with the
5 standards, rules, and regulations of the Department of
6 Healthcare and Family Services, with due regard to the
7 requirements and conditions in each case, including
8 contributions available from legally responsible relatives.
9 However, the amount and nature of such medical assistance shall
10 not be affected by the payment of any grant under the Senior
11 Citizens and Disabled Persons Property Tax Relief ~~and~~
12 ~~Pharmaceutical Assistance~~ Act or any distributions or items of
13 income described under subparagraph (X) of paragraph (2) of
14 subsection (a) of Section 203 of the Illinois Income Tax Act.
15 The amount and nature of medical assistance shall not be
16 affected by the receipt of donations or benefits from
17 fundraisers in cases of serious illness, as long as neither the
18 person nor members of the person's family have actual control
19 over the donations or benefits or the disbursement of the
20 donations or benefits.

21 In determining the income and resources ~~assets~~ available to
22 the institutionalized spouse and to the community spouse, the
23 Department of Healthcare and Family Services shall follow the
24 procedures established by federal law. If an institutionalized
25 spouse or community spouse refuses to comply with the

1 requirements of Title XIX of the federal Social Security Act
2 and the regulations duly promulgated thereunder by failing to
3 provide the total value of assets, including income and
4 resources, to the extent either the institutionalized spouse or
5 community spouse has an ownership interest in them pursuant to
6 42 U.S.C. 1396r-5, such refusal may result in the
7 institutionalized spouse being denied eligibility and
8 continuing to remain ineligible for the medical assistance
9 program based on failure to cooperate.

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

1 (b) Spousal support for institutionalized spouses
2 receiving medical assistance.

3 (i) The Department may seek support for an
4 institutionalized spouse, who has assigned his or her right
5 of support from his or her spouse to the State, from the
6 resources and income available to the community spouse.

7 (ii) The Department may bring an action in the circuit
8 court to establish support orders or itself establish
9 administrative support orders by any means and procedures
10 authorized in this Code, as applicable, except that the
11 standard and regulations for determining ability to
12 support in Section 10-3 shall not limit the amount of
13 support that may be ordered.

14 (iii) Proceedings may be initiated to obtain support,
15 or for the recovery of aid granted during the period such
16 support was not provided, or both, for the obtainment of
17 support and the recovery of the aid provided. Proceedings
18 for the recovery of aid may be taken separately or they may
19 be consolidated with actions to obtain support. Such
20 proceedings may be brought in the name of the person or
21 persons requiring support or may be brought in the name of
22 the Department, as the case requires.

23 (iv) The orders for the payment of moneys for the
24 support of the person shall be just and equitable and may
25 direct payment thereof for such period or periods of time
26 as the circumstances require, including support for a

1 period before the date the order for support is entered. In
2 no event shall the orders reduce the community spouse
3 resource allowance below the level established in
4 subsection (a) of this Section or an amount set after a
5 fair hearing, whichever is greater, or reduce the monthly
6 maintenance allowance for the community spouse below the
7 level permitted pursuant to subsection (a) of this Section.

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

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

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

24 Sec. 5-4.1. Co-payments. The Department may by rule provide
25 that recipients under any Article of this Code shall pay a fee

1 as a co-payment for services. Co-payments shall be maximized to
2 the extent permitted by federal law, except that the Department
3 shall impose a co-pay of \$2 on generic drugs. Provided,
4 however, that any such rule must provide that no co-payment
5 requirement can exist for renal dialysis, radiation therapy,
6 cancer chemotherapy, or insulin, and other products necessary
7 on a recurring basis, the absence of which would be life
8 threatening, or where co-payment expenditures for required
9 services and/or medications for chronic diseases that the
10 Illinois Department shall by rule designate shall cause an
11 extensive financial burden on the recipient, and provided no
12 co-payment shall exist for emergency room encounters which are
13 for medical emergencies. The Department shall seek approval of
14 a State plan amendment that allows pharmacies to refuse to
15 dispense drugs in circumstances where the recipient does not
16 pay the required co-payment. ~~In the event the State plan~~
17 ~~amendment is rejected, co payments may not exceed \$3 for brand~~
18 ~~name drugs, \$1 for other pharmacy services other than for~~
19 ~~generic drugs, and \$2 for physician services, dental services,~~
20 ~~optical services and supplies, chiropractic services, podiatry~~
21 ~~services, and encounter rate clinic services. There shall be no~~
22 ~~co-payment for generic drugs.~~ Co-payments may not exceed \$10
23 for emergency room use for a non-emergency situation as defined
24 by the Department by rule and subject to federal approval.

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

1 (305 ILCS 5/5-4.2) (from Ch. 23, par. 5-4.2)

2 Sec. 5-4.2. Ambulance services payments.

3 (a) For ambulance services provided to a recipient of aid
4 under this Article on or after January 1, 1993, the Illinois
5 Department shall reimburse ambulance service providers at
6 rates calculated in accordance with this Section. It is the
7 intent of the General Assembly to provide adequate
8 reimbursement for ambulance services so as to ensure adequate
9 access to services for recipients of aid under this Article and
10 to provide appropriate incentives to ambulance service
11 providers to provide services in an efficient and
12 cost-effective manner. Thus, it is the intent of the General
13 Assembly that the Illinois Department implement a
14 reimbursement system for ambulance services that, to the extent
15 practicable and subject to the availability of funds
16 appropriated by the General Assembly for this purpose, is
17 consistent with the payment principles of Medicare. To ensure
18 uniformity between the payment principles of Medicare and
19 Medicaid, the Illinois Department shall follow, to the extent
20 necessary and practicable and subject to the availability of
21 funds appropriated by the General Assembly for this purpose,
22 the statutes, laws, regulations, policies, procedures,
23 principles, definitions, guidelines, and manuals used to
24 determine the amounts paid to ambulance service providers under
25 Title XVIII of the Social Security Act (Medicare).

26 (b) For ambulance services provided to a recipient of aid

1 under this Article on or after January 1, 1996, the Illinois
2 Department shall reimburse ambulance service providers based
3 upon the actual distance traveled if a natural disaster,
4 weather conditions, road repairs, or traffic congestion
5 necessitates the use of a route other than the most direct
6 route.

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

10 (c-1) For purposes of this Section, "ground ambulance
11 service" means medical transportation services that are
12 described as ground ambulance services by the Centers for
13 Medicare and Medicaid Services and provided in a vehicle that
14 is licensed as an ambulance by the Illinois Department of
15 Public Health pursuant to the Emergency Medical Services (EMS)
16 Systems Act.

17 (c-2) For purposes of this Section, "ground ambulance
18 service provider" means a vehicle service provider as described
19 in the Emergency Medical Services (EMS) Systems Act that
20 operates licensed ambulances for the purpose of providing
21 emergency ambulance services, or non-emergency ambulance
22 services, or both. For purposes of this Section, this includes
23 both ambulance providers and ambulance suppliers as described
24 by the Centers for Medicare and Medicaid Services.

25 (d) This Section does not prohibit separate billing by
26 ambulance service providers for oxygen furnished while

1 providing advanced life support services.

2 (e) Beginning with services rendered on or after July 1,
3 2008, all providers of non-emergency medi-car and service car
4 transportation must certify that the driver and employee
5 attendant, as applicable, have completed a safety program
6 approved by the Department to protect both the patient and the
7 driver, prior to transporting a patient. The provider must
8 maintain this certification in its records. The provider shall
9 produce such documentation upon demand by the Department or its
10 representative. Failure to produce documentation of such
11 training shall result in recovery of any payments made by the
12 Department for services rendered by a non-certified driver or
13 employee attendant. Medi-car and service car providers must
14 maintain legible documentation in their records of the driver
15 and, as applicable, employee attendant that actually
16 transported the patient. Providers must recertify all drivers
17 and employee attendants every 3 years.

18 Notwithstanding the requirements above, any public
19 transportation provider of medi-car and service car
20 transportation that receives federal funding under 49 U.S.C.
21 5307 and 5311 need not certify its drivers and employee
22 attendants under this Section, since safety training is already
23 federally mandated.

24 (f) With respect to any policy or program administered by
25 the Department or its agent regarding approval of non-emergency
26 medical transportation by ground ambulance service providers,

1 including, but not limited to, the Non-Emergency
2 Transportation Services Prior Approval Program (NETSPAP), the
3 Department shall establish by rule a process by which ground
4 ambulance service providers of non-emergency medical
5 transportation may appeal any decision by the Department or its
6 agent for which no denial was received prior to the time of
7 transport that either (i) denies a request for approval for
8 payment of non-emergency transportation by means of ground
9 ambulance service or (ii) grants a request for approval of
10 non-emergency transportation by means of ground ambulance
11 service at a level of service that entitles the ground
12 ambulance service provider to a lower level of compensation
13 from the Department than the ground ambulance service provider
14 would have received as compensation for the level of service
15 requested. The rule shall be filed by December 15, 2012
16 ~~established within 12 months after the effective date of this~~
17 ~~amendatory Act of the 97th General Assembly~~ and shall provide
18 that, for any decision rendered by the Department or its agent
19 on or after the date the rule takes effect, the ground
20 ambulance service provider shall have 60 days from the date the
21 decision is received to file an appeal. The rule established by
22 the Department shall be, insofar as is practical, consistent
23 with the Illinois Administrative Procedure Act. The Director's
24 decision on an appeal under this Section shall be a final
25 administrative decision subject to review under the
26 Administrative Review Law.

1 (g) Whenever a patient covered by a medical assistance
2 program under this Code or by another medical program
3 administered by the Department is being discharged from a
4 facility, a physician discharge order as described in this
5 Section shall be required for each patient whose discharge
6 requires medically supervised ground ambulance services.
7 Facilities shall develop procedures for a physician with
8 medical staff privileges to provide a written and signed
9 physician discharge order. The physician discharge order shall
10 specify the level of ground ambulance services needed and
11 complete a medical certification establishing the criteria for
12 approval of non-emergency ambulance transportation, as
13 published by the Department of Healthcare and Family Services,
14 that is met by the patient. This order and the medical
15 certification shall be completed prior to ordering an ambulance
16 service and prior to patient discharge.

17 Pursuant to subsection (E) of Section 12-4.25 of this Code,
18 the Department is entitled to recover overpayments paid to a
19 provider or vendor, including, but not limited to, from the
20 discharging physician, the discharging facility, and the
21 ground ambulance service provider, in instances where a
22 non-emergency ground ambulance service is rendered as the
23 result of improper or false certification.

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

1 rate of reimbursement for services or other payments in
2 accordance with Section 5-5e.

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

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

5 Sec. 5-5. Medical services. The Illinois Department, by
6 rule, shall determine the quantity and quality of and the rate
7 of reimbursement for the medical assistance for which payment
8 will be authorized, and the medical services to be provided,
9 which may include all or part of the following: (1) inpatient
10 hospital services; (2) outpatient hospital services; (3) other
11 laboratory and X-ray services; (4) skilled nursing home
12 services; (5) physicians' services whether furnished in the
13 office, the patient's home, a hospital, a skilled nursing home,
14 or elsewhere; (6) medical care, or any other type of remedial
15 care furnished by licensed practitioners; (7) home health care
16 services; (8) private duty nursing service; (9) clinic
17 services; (10) dental services, including prevention and
18 treatment of periodontal disease and dental caries disease for
19 pregnant women, provided by an individual licensed to practice
20 dentistry or dental surgery; for purposes of this item (10),
21 "dental services" means diagnostic, preventive, or corrective
22 procedures provided by or under the supervision of a dentist in
23 the practice of his or her profession; (11) physical therapy
24 and related services; (12) prescribed drugs, dentures, and
25 prosthetic devices; and eyeglasses prescribed by a physician

1 skilled in the diseases of the eye, or by an optometrist,
2 whichever the person may select; (13) other diagnostic,
3 screening, preventive, and rehabilitative services, for
4 children and adults; (14) transportation and such other
5 expenses as may be necessary; (15) medical treatment of sexual
6 assault survivors, as defined in Section 1a of the Sexual
7 Assault Survivors Emergency Treatment Act, for injuries
8 sustained as a result of the sexual assault, including
9 examinations and laboratory tests to discover evidence which
10 may be used in criminal proceedings arising from the sexual
11 assault; (16) the diagnosis and treatment of sickle cell
12 anemia; and (17) any other medical care, and any other type of
13 remedial care recognized under the laws of this State, but not
14 including abortions, or induced miscarriages or premature
15 births, unless, in the opinion of a physician, such procedures
16 are necessary for the preservation of the life of the woman
17 seeking such treatment, or except an induced premature birth
18 intended to produce a live viable child and such procedure is
19 necessary for the health of the mother or her unborn child. The
20 Illinois Department, by rule, shall prohibit any physician from
21 providing medical assistance to anyone eligible therefor under
22 this Code where such physician has been found guilty of
23 performing an abortion procedure in a wilful and wanton manner
24 upon a woman who was not pregnant at the time such abortion
25 procedure was performed. The term "any other type of remedial
26 care" shall include nursing care and nursing home service for

1 persons who rely on treatment by spiritual means alone through
2 prayer for healing.

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

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

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

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

25 (2) eyeglasses prescribed by a physician skilled in the
26 diseases of the eye, or by an optometrist, whichever the

1 person may select.

2 Notwithstanding any other provision of this Code and
3 subject to federal approval, the Department may adopt rules to
4 allow a dentist who is volunteering his or her service at no
5 cost to render dental services through an enrolled
6 not-for-profit health clinic without the dentist personally
7 enrolling as a participating provider in the medical assistance
8 program. A not-for-profit health clinic shall include a public
9 health clinic or Federally Qualified Health Center or other
10 enrolled provider, as determined by the Department, through
11 which dental services covered under this Section are performed.
12 The Department shall establish a process for payment of claims
13 for reimbursement for covered dental services rendered under
14 this provision.

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

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

25 The Illinois Department shall authorize the provision of,
26 and shall authorize payment for, screening by low-dose

1 mammography for the presence of occult breast cancer for women
2 35 years of age or older who are eligible for medical
3 assistance under this Article, as follows:

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

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

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

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

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

1 includes digital mammography.

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

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

11 Subject to federal approval, the Department shall
12 establish a rate methodology for mammography at federally
13 qualified health centers and other encounter-rate clinics.
14 These clinics or centers may also collaborate with other
15 hospital-based mammography facilities.

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

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

26 The Department shall devise a means of case-managing or

1 patient navigation for beneficiaries diagnosed with breast
2 cancer. This program shall initially operate as a pilot program
3 in areas of the State with the highest incidence of mortality
4 related to breast cancer. At least one pilot program site shall
5 be in the metropolitan Chicago area and at least one site shall
6 be outside the metropolitan Chicago area. An evaluation of the
7 pilot program shall be carried out measuring health outcomes
8 and cost of care for those served by the pilot program compared
9 to similarly situated patients who are not served by the pilot
10 program.

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

23 All medical providers providing medical assistance to
24 pregnant women under this Code shall receive information from
25 the Department on the availability of services under the Drug
26 Free Families with a Future or any comparable program providing

1 case management services for addicted women, including
2 information on appropriate referrals for other social services
3 that may be needed by addicted women in addition to treatment
4 for addiction.

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

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

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

25 ~~Notwithstanding any other provision of law, a health care~~
26 ~~provider under the medical assistance program may elect, in~~

1 ~~lieu of receiving direct payment for services provided under~~
2 ~~that program, to participate in the State Employees Deferred~~
3 ~~Compensation Plan adopted under Article 24 of the Illinois~~
4 ~~Pension Code. A health care provider who elects to participate~~
5 ~~in the plan does not have a cause of action against the State~~
6 ~~for any damages allegedly suffered by the provider as a result~~
7 ~~of any delay by the State in crediting the amount of any~~
8 ~~contribution to the provider's plan account.~~

9 The Illinois Department may develop and contract with
10 Partnerships of medical providers to arrange medical services
11 for persons eligible under Section 5-2 of this Code.
12 Implementation of this Section may be by demonstration projects
13 in certain geographic areas. The Partnership shall be
14 represented by a sponsor organization. The Department, by rule,
15 shall develop qualifications for sponsors of Partnerships.
16 Nothing in this Section shall be construed to require that the
17 sponsor organization be a medical organization.

18 The sponsor must negotiate formal written contracts with
19 medical providers for physician services, inpatient and
20 outpatient hospital care, home health services, treatment for
21 alcoholism and substance abuse, and other services determined
22 necessary by the Illinois Department by rule for delivery by
23 Partnerships. Physician services must include prenatal and
24 obstetrical care. The Illinois Department shall reimburse
25 medical services delivered by Partnership providers to clients
26 in target areas according to provisions of this Article and the

1 Illinois Health Finance Reform Act, except that:

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

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

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

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

23 Nothing in this Section shall limit the free choice of
24 practitioners, hospitals, and other providers of medical
25 services by clients. In order to ensure patient freedom of
26 choice, the Illinois Department shall immediately promulgate

1 all rules and take all other necessary actions so that provided
2 services may be accessed from therapeutically certified
3 optometrists to the full extent of the Illinois Optometric
4 Practice Act of 1987 without discriminating between service
5 providers.

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

9 The Illinois Department shall require health care
10 providers to maintain records that document the medical care
11 and services provided to recipients of Medical Assistance under
12 this Article. Such records must be retained for a period of not
13 less than 6 years from the date of service or as provided by
14 applicable State law, whichever period is longer, except that
15 if an audit is initiated within the required retention period
16 then the records must be retained until the audit is completed
17 and every exception is resolved. The Illinois Department shall
18 require health care providers to make available, when
19 authorized by the patient, in writing, the medical records in a
20 timely fashion to other health care providers who are treating
21 or serving persons eligible for Medical Assistance under this
22 Article. All dispensers of medical services shall be required
23 to maintain and retain business and professional records
24 sufficient to fully and accurately document the nature, scope,
25 details and receipt of the health care provided to persons
26 eligible for medical assistance under this Code, in accordance

1 with regulations promulgated by the Illinois Department. The
2 rules and regulations shall require that proof of the receipt
3 of prescription drugs, dentures, prosthetic devices and
4 eyeglasses by eligible persons under this Section accompany
5 each claim for reimbursement submitted by the dispenser of such
6 medical services. No such claims for reimbursement shall be
7 approved for payment by the Illinois Department without such
8 proof of receipt, unless the Illinois Department shall have put
9 into effect and shall be operating a system of post-payment
10 audit and review which shall, on a sampling basis, be deemed
11 adequate by the Illinois Department to assure that such drugs,
12 dentures, prosthetic devices and eyeglasses for which payment
13 is being made are actually being received by eligible
14 recipients. Within 90 days after the effective date of this
15 amendatory Act of 1984, the Illinois Department shall establish
16 a current list of acquisition costs for all prosthetic devices
17 and any other items recognized as medical equipment and
18 supplies reimbursable under this Article and shall update such
19 list on a quarterly basis, except that the acquisition costs of
20 all prescription drugs shall be updated no less frequently than
21 every 30 days as required by Section 5-5.12.

22 The rules and regulations of the Illinois Department shall
23 require that a written statement including the required opinion
24 of a physician shall accompany any claim for reimbursement for
25 abortions, or induced miscarriages or premature births. This
26 statement shall indicate what procedures were used in providing

1 such medical services.

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

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

19 Enrollment of a vendor ~~that provides non-emergency medical~~
20 ~~transportation, defined by the Department by rule,~~ shall be
21 subject to a provisional period and shall be conditional for
22 one year ~~180~~ days. During the period of conditional enrollment
23 ~~that time,~~ the Department ~~of Healthcare and Family Services~~ may
24 terminate the vendor's eligibility to participate in, or may
25 disenroll the vendor from, the medical assistance program
26 without cause. Unless otherwise specified, such ~~That~~

1 termination of eligibility or disenrollment is not subject to
2 the Department's hearing process. However, a disenrolled
3 vendor may reapply without penalty.

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

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

19 The Department shall define or specify the following: (i)
20 by provider notice, the "category of risk of the vendor" for
21 each type of vendor, which shall take into account the level of
22 screening applicable to a particular category of vendor under
23 federal law and regulations; (ii) by rule or provider notice,
24 the maximum length of the conditional enrollment period for
25 each category of risk of the vendor; and (iii) by rule, the
26 hearing rights, if any, afforded to a vendor in each category

1 of risk of the vendor that is terminated or disenrolled during
2 the conditional enrollment period.

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

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

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

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

22 For claims for services rendered during a period for which
23 a recipient received retroactive eligibility, claims must be
24 filed within 180 days after the Department determines the
25 applicant is eligible. For claims for which the Illinois
26 Department is not the primary payer, claims must be submitted

1 to the Illinois Department within 180 days after the final
2 adjudication by the primary payer.

3 In the case of long term care facilities, admission
4 documents shall be submitted within 30 days of an admission to
5 the facility through the Medical Electronic Data Interchange
6 (MEDI) or the Recipient Eligibility Verification (REV) System,
7 or shall be submitted directly to the Department of Human
8 Services using required admission forms. Confirmation numbers
9 assigned to an accepted transaction shall be retained by a
10 facility to verify timely submittal. Once an admission
11 transaction has been completed, all resubmitted claims
12 following prior rejection are subject to receipt no later than
13 180 days after the admission transaction has been completed.

14 Claims that are not submitted and received in compliance
15 with the foregoing requirements shall not be eligible for
16 payment under the medical assistance program, and the State
17 shall have no liability for payment of those claims.

18 To the extent consistent with applicable information and
19 privacy, security, and disclosure laws, State and federal
20 agencies and departments shall provide the Illinois Department
21 access to confidential and other information and data necessary
22 to perform eligibility and payment verifications and other
23 Illinois Department functions. This includes, but is not
24 limited to: information pertaining to licensure;
25 certification; earnings; immigration status; citizenship; wage
26 reporting; unearned and earned income; pension income;

1 employment; supplemental security income; social security
2 numbers; National Provider Identifier (NPI) numbers; the
3 National Practitioner Data Bank (NPDB); program and agency
4 exclusions; taxpayer identification numbers; tax delinquency;
5 corporate information; and death records.

6 The Illinois Department shall enter into agreements with
7 State agencies and departments, and is authorized to enter into
8 agreements with federal agencies and departments, under which
9 such agencies and departments shall share data necessary for
10 medical assistance program integrity functions and oversight.

11 The Illinois Department shall develop, in cooperation with
12 other State departments and agencies, and in compliance with
13 applicable federal laws and regulations, appropriate and
14 effective methods to share such data. At a minimum, and to the
15 extent necessary to provide data sharing, the Illinois
16 Department shall enter into agreements with State agencies and
17 departments, and is authorized to enter into agreements with
18 federal agencies and departments, including but not limited to:
19 the Secretary of State; the Department of Revenue; the
20 Department of Public Health; the Department of Human Services;
21 and the Department of Financial and Professional Regulation.

22 Beginning in fiscal year 2013, the Illinois Department
23 shall set forth a request for information to identify the
24 benefits of a pre-payment, post-adjudication, and post-edit
25 claims system with the goals of streamlining claims processing
26 and provider reimbursement, reducing the number of pending or

1 rejected claims, and helping to ensure a more transparent
2 adjudication process through the utilization of: (i) provider
3 data verification and provider screening technology; and (ii)
4 clinical code editing; and (iii) pre-pay, pre- or
5 post-adjudicated predictive modeling with an integrated case
6 management system with link analysis. Such a request for
7 information shall not be considered as a request for proposal
8 or as an obligation on the part of the Illinois Department to
9 take any action or acquire any products or services.

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

26 The Department shall execute, relative to the nursing home

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

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

8 The Illinois Department shall report annually to the
9 General Assembly, no later than the second Friday in April of
10 1979 and each year thereafter, in regard to:

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

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

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

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

19 The period covered by each report shall be the 3 years
20 ending on the June 30 prior to the report. The report shall
21 include suggested legislation for consideration by the General
22 Assembly. The filing of one copy of the report with the
23 Speaker, one copy with the Minority Leader and one copy with
24 the Clerk of the House of Representatives, one copy with the
25 President, one copy with the Minority Leader and one copy with
26 the Secretary of the Senate, one copy with the Legislative

1 Research Unit, and such additional copies with the State
2 Government Report Distribution Center for the General Assembly
3 as is required under paragraph (t) of Section 7 of the State
4 Library Act shall be deemed sufficient to comply with this
5 Section.

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

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

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

20 (305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

21 Sec. 5-5.02. Hospital reimbursements.

22 (a) Reimbursement to Hospitals; July 1, 1992 through
23 September 30, 1992. Notwithstanding any other provisions of
24 this Code or the Illinois Department's Rules promulgated under
25 the Illinois Administrative Procedure Act, reimbursement to

1 hospitals for services provided during the period July 1, 1992
2 through September 30, 1992, shall be as follows:

3 (1) For inpatient hospital services rendered, or if
4 applicable, for inpatient hospital discharges occurring,
5 on or after July 1, 1992 and on or before September 30,
6 1992, the Illinois Department shall reimburse hospitals
7 for inpatient services under the reimbursement
8 methodologies in effect for each hospital, and at the
9 inpatient payment rate calculated for each hospital, as of
10 June 30, 1992. For purposes of this paragraph,
11 "reimbursement methodologies" means all reimbursement
12 methodologies that pertain to the provision of inpatient
13 hospital services, including, but not limited to, any
14 adjustments for disproportionate share, targeted access,
15 critical care access and uncompensated care, as defined by
16 the Illinois Department on June 30, 1992.

17 (2) For the purpose of calculating the inpatient
18 payment rate for each hospital eligible to receive
19 quarterly adjustment payments for targeted access and
20 critical care, as defined by the Illinois Department on
21 June 30, 1992, the adjustment payment for the period July
22 1, 1992 through September 30, 1992, shall be 25% of the
23 annual adjustment payments calculated for each eligible
24 hospital, as of June 30, 1992. The Illinois Department
25 shall determine by rule the adjustment payments for
26 targeted access and critical care beginning October 1,

1 1992.

2 (3) For the purpose of calculating the inpatient
3 payment rate for each hospital eligible to receive
4 quarterly adjustment payments for uncompensated care, as
5 defined by the Illinois Department on June 30, 1992, the
6 adjustment payment for the period August 1, 1992 through
7 September 30, 1992, shall be one-sixth of the total
8 uncompensated care adjustment payments calculated for each
9 eligible hospital for the uncompensated care rate year, as
10 defined by the Illinois Department, ending on July 31,
11 1992. The Illinois Department shall determine by rule the
12 adjustment payments for uncompensated care beginning
13 October 1, 1992.

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

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

1 or

2 (2) Illinois hospitals that have a Medicaid inpatient
3 utilization rate which is at least one-half a standard
4 deviation above the mean Medicaid inpatient utilization
5 rate for all hospitals in Illinois receiving Medicaid
6 payments from the Illinois Department; or

7 (3) Illinois hospitals that on July 1, 1991 had a
8 Medicaid inpatient utilization rate, as defined in
9 paragraph (h) of this Section, that was at least the mean
10 Medicaid inpatient utilization rate for all hospitals in
11 Illinois receiving Medicaid payments from the Illinois
12 Department and which were located in a planning area with
13 one-third or fewer excess beds as determined by the Health
14 Facilities and Services Review Board, and that, as of June
15 30, 1992, were located in a federally designated Health
16 Manpower Shortage Area; or

17 (4) Illinois hospitals that:

18 (A) have a Medicaid inpatient utilization rate
19 that is at least equal to the mean Medicaid inpatient
20 utilization rate for all hospitals in Illinois
21 receiving Medicaid payments from the Department; and

22 (B) also have a Medicaid obstetrical inpatient
23 utilization rate that is at least one standard
24 deviation above the mean Medicaid obstetrical
25 inpatient utilization rate for all hospitals in
26 Illinois receiving Medicaid payments from the

1 Department for obstetrical services; or

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

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

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

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

1 the sum of \$25 plus \$1 for each one percent that the
2 hospital's Medicaid inpatient utilization rate exceeds the
3 mean Medicaid inpatient utilization rate;

4 (3) hospitals with a Medicaid inpatient utilization
5 rate that is equal to or greater than one standard
6 deviation above the mean Medicaid inpatient utilization
7 rate but less than 1.5 standard deviations above the mean
8 Medicaid inpatient utilization rate shall receive a per day
9 adjustment payment equal to the sum of \$40 plus \$7 for each
10 one percent that the hospital's Medicaid inpatient
11 utilization rate exceeds one standard deviation above the
12 mean Medicaid inpatient utilization rate; and

13 (4) hospitals with a Medicaid inpatient utilization
14 rate that is equal to or greater than 1.5 standard
15 deviations above the mean Medicaid inpatient utilization
16 rate shall receive a per day adjustment payment equal to
17 the sum of \$90 plus \$2 for each one percent that the
18 hospital's Medicaid inpatient utilization rate exceeds 1.5
19 standard deviations above the mean Medicaid inpatient
20 utilization rate.

21 (d) Supplemental adjustment payments. In addition to the
22 adjustment payments described in paragraph (c), hospitals as
23 defined in clauses (1) through (5) of paragraph (b), excluding
24 county hospitals (as defined in subsection (c) of Section 15-1
25 of this Code) and a hospital organized under the University of
26 Illinois Hospital Act, shall be paid supplemental inpatient

1 adjustment payments of \$60 per day. For purposes of Title XIX
2 of the federal Social Security Act, these supplemental
3 adjustment payments shall not be classified as adjustment
4 payments to disproportionate share hospitals.

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

24 (f) Children's hospital inpatient adjustment payments. For
25 children's hospitals, as defined in clause (5) of paragraph
26 (b), the adjustment payments required pursuant to paragraphs

1 (c) and (d) shall be multiplied by 2.0.

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

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

8 (1) "Medicaid inpatient utilization rate" means a
9 fraction, the numerator of which is the number of a
10 hospital's inpatient days provided in a given 12-month
11 period to patients who, for such days, were eligible for
12 Medicaid under Title XIX of the federal Social Security
13 Act, and the denominator of which is the total number of
14 the hospital's inpatient days in that same period.

15 (2) "Mean Medicaid inpatient utilization rate" means
16 the total number of Medicaid inpatient days provided by all
17 Illinois Medicaid-participating hospitals divided by the
18 total number of inpatient days provided by those same
19 hospitals.

20 (3) "Medicaid obstetrical inpatient utilization rate"
21 means the ratio of Medicaid obstetrical inpatient days to
22 total Medicaid inpatient days for all Illinois hospitals
23 receiving Medicaid payments from the Illinois Department.

24 (i) Inpatient adjustment payment limit. In order to meet
25 the limits of Public Law 102-234 and Public Law 103-66, the
26 Illinois Department shall by rule adjust disproportionate

1 share adjustment payments.

2 (j) University of Illinois Hospital inpatient adjustment
3 payments. For hospitals organized under the University of
4 Illinois Hospital Act, there shall be an adjustment payment as
5 determined by rules adopted by the Illinois Department.

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

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

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

15 (305 ILCS 5/5-5.05)

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

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

20 (b) For purposes of this Section, "hospital" means the
21 following:

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

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

24 (3) BroMenn Healthcare, Bloomington, Illinois.

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

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

2 (6) Lawrence County Memorial Hospital, Lawrenceville,
3 Illinois.

4 (7) Advocate Lutheran General Hospital, Park Ridge,
5 Illinois.

6 (8) Mercy Hospital and Medical Center, Chicago,
7 Illinois.

8 (9) Methodist Medical Center of Illinois, Peoria,
9 Illinois.

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

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

13 (12) Sarah Bush Lincoln Health Center, Mattoon,
14 Illinois.

15 (13) Provena Covenant Medical Center, Urbana,
16 Illinois.

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

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

20 (16) Gateway Regional Medical Center, Granite City,
21 Illinois.

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

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

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

25 (20) Memorial Hospital, Belleville, Illinois.

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

- 1 (22) Trinity Medical Center, Rock Island, Illinois.
2 (23) St. Elizabeth Hospital, Chicago, Illinois.
3 (24) Richland Memorial Hospital, Olney, Illinois.
4 (25) St. Elizabeth's Hospital, Belleville, Illinois.
5 (26) Samaritan Health System, Clinton, Iowa.
6 (27) St. John's Hospital, Springfield, Illinois.
7 (28) St. Mary's Hospital, Centralia, Illinois.
8 (29) Loretto Hospital, Chicago, Illinois.
9 (30) Kenneth Hall Regional Hospital, East St. Louis,
10 Illinois.
11 (31) Hinsdale Hospital, Hinsdale, Illinois.
12 (32) Pekin Hospital, Pekin, Illinois.
13 (33) University of Chicago Medical Center, Chicago,
14 Illinois.
15 (34) St. Anthony's Health Center, Alton, Illinois.
16 (35) OSF St. Francis Medical Center, Peoria, Illinois.
17 (36) Memorial Medical Center, Springfield, Illinois.
18 (37) A hospital with a distinct part unit for
19 psychiatric services that begins operating on or after July
20 1, 2008.

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

25 (c) No rules shall be promulgated to implement this
26 Section. For purposes of this Section, "rules" is given the

1 meaning contained in Section 1-70 of the Illinois
2 Administrative Procedure Act.

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

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

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

14 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

15 Sec. 5-5.2. Payment.

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

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

22 (c) Notwithstanding any other provisions of this Code,
23 ~~beginning July 1, 2012~~ the methodologies for reimbursement of
24 nursing ~~facility~~ services as provided under this Article shall
25 no longer be applicable for bills payable for nursing services

1 rendered on or after a new reimbursement system based on the
2 Resource Utilization Groups (RUGs) has been fully
3 operationalized, which shall take effect for services provided
4 on or after January 1, 2014. State fiscal years 2012 and
5 thereafter. The Department of Healthcare and Family Services
6 shall, effective July 1, 2012, implement an evidence based
7 payment methodology for the reimbursement of nursing facility
8 services. The methodology shall continue to take into
9 consideration the needs of individual residents, as assessed
10 and reported by the most current version of the nursing
11 facility Resident Assessment Instrument, adopted and in use by
12 the federal government.

13 (d) A new nursing services reimbursement methodology
14 utilizing RUGs IV 48 grouper model shall be established and may
15 include an Illinois-specific default group, as needed. The new
16 RUGs-based nursing services reimbursement methodology shall be
17 resident-driven, facility-specific, and cost-based. Costs
18 shall be annually rebased and case mix index quarterly updated.
19 The methodology shall include regional wage adjustors based on
20 the Health Service Areas (HSA) groupings in effect on April 30,
21 2012. The Department shall assign a case mix index to each
22 resident class based on the Centers for Medicare and Medicaid
23 Services staff time measurement study utilizing an index
24 maximization approach.

25 (e) Notwithstanding any other provision of this Code, the
26 Department shall by rule develop a reimbursement methodology

1 reflective of the intensity of care and services requirements
2 of low need residents in the lowest RUG IV groupers and
3 corresponding regulations.

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

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

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

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

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

22 (h) Notwithstanding any other provision of this Code, on
23 and after July 1, 2012, nursing facilities designated by the
24 Department of Healthcare and Family Services as "Institutions
25 for Mental Disease" and "Institutions for Mental Disease" that
26 are facilities licensed under the Specialized Mental Health

1 Rehabilitation Act shall have the nursing,
2 socio-developmental, capital, and support components of their
3 reimbursement rate effective May 1, 2011 reduced in total by
4 2.7%.

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

6 (305 ILCS 5/5-5.3) (from Ch. 23, par. 5-5.3)

7 Sec. 5-5.3. Conditions of Payment - Prospective Rates -
8 Accounting Principles. This amendatory Act establishes certain
9 conditions for the Department of Healthcare and Family Services
10 in instituting rates for the care of recipients of medical
11 assistance in nursing facilities and ICF/DDs. Such conditions
12 shall assure a method under which the payment for nursing
13 facility and ICF/DD services provided to recipients under the
14 Medical Assistance Program shall be on a reasonable cost
15 related basis, which is prospectively determined at least
16 annually by the Department of Public Aid (now Healthcare and
17 Family Services). The annually established payment rate shall
18 take effect on July 1 in 1984 and subsequent years. There shall
19 be no rate increase during calendar year 1983 and the first six
20 months of calendar year 1984.

21 The determination of the payment shall be made on the basis
22 of generally accepted accounting principles that shall take
23 into account the actual costs to the facility of providing
24 nursing facility and ICF/DD services to recipients under the
25 medical assistance program.

1 The resultant total rate for a specified type of service
2 shall be an amount which shall have been determined to be
3 adequate to reimburse allowable costs of a facility that is
4 economically and efficiently operated. The Department shall
5 establish an effective date for each facility or group of
6 facilities after which rates shall be paid on a reasonable cost
7 related basis which shall be no sooner than the effective date
8 of this amendatory Act of 1977.

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

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

15 (305 ILCS 5/5-5.4) (from Ch. 23, par. 5-5.4)

16 Sec. 5-5.4. Standards of Payment - Department of Healthcare
17 and Family Services. The Department of Healthcare and Family
18 Services shall develop standards of payment of nursing facility
19 and ICF/DD services in facilities providing such services under
20 this Article which:

21 (1) Provide for the determination of a facility's payment
22 for nursing facility or ICF/DD services on a prospective basis.
23 The amount of the payment rate for all nursing facilities
24 certified by the Department of Public Health under the ID/DD
25 Community Care Act or the Nursing Home Care Act as Intermediate

1 Care for the Developmentally Disabled facilities, Long Term
2 Care for Under Age 22 facilities, Skilled Nursing facilities,
3 or Intermediate Care facilities under the medical assistance
4 program shall be prospectively established annually on the
5 basis of historical, financial, and statistical data
6 reflecting actual costs from prior years, which shall be
7 applied to the current rate year and updated for inflation,
8 except that the capital cost element for newly constructed
9 facilities shall be based upon projected budgets. The annually
10 established payment rate shall take effect on July 1 in 1984
11 and subsequent years. No rate increase and no update for
12 inflation shall be provided on or after July 1, 1994 and before
13 January 1, 2014 ~~July 1, 2012~~, unless specifically provided for
14 in this Section. The changes made by Public Act 93-841
15 extending the duration of the prohibition against a rate
16 increase or update for inflation are effective retroactive to
17 July 1, 2004.

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

1 Department. For facilities licensed by the Department of Public
2 Health under the Nursing Home Care Act as Intermediate Care
3 Facilities for the Developmentally Disabled or Long Term Care
4 for Under Age 22 facilities, the rates taking effect on January
5 1, 2006 shall include an increase of 3%. For facilities
6 licensed by the Department of Public Health under the Nursing
7 Home Care Act as Intermediate Care Facilities for the
8 Developmentally Disabled or Long Term Care for Under Age 22
9 facilities, the rates taking effect on January 1, 2009 shall
10 include an increase sufficient to provide a \$0.50 per hour wage
11 increase for non-executive staff.

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

24 For facilities licensed by the Department of Public Health
25 under the Nursing Home Care Act as Intermediate Care for the
26 Developmentally Disabled facilities or Long Term Care for Under

1 Age 22 facilities, the rates taking effect on July 1, 2000
2 shall include an increase of 2.5% per resident-day, as defined
3 by the Department. For facilities licensed by the Department of
4 Public Health under the Nursing Home Care Act as Skilled
5 Nursing facilities or Intermediate Care facilities, the rates
6 taking effect on July 1, 2000 shall include an increase of 2.5%
7 per resident-day, as defined by the Department.

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

24 (A) For a facility that would receive a lower nursing
25 component rate per patient day under the new system than
26 the facility received effective on the date immediately

1 preceding the date that the Department implements the new
2 payment methodology, the nursing component rate per
3 patient day for the facility shall be held at the level in
4 effect on the date immediately preceding the date that the
5 Department implements the new payment methodology until a
6 higher nursing component rate of reimbursement is achieved
7 by that facility.

8 (B) For a facility that would receive a higher nursing
9 component rate per patient day under the payment
10 methodology in effect on July 1, 2003 than the facility
11 received effective on the date immediately preceding the
12 date that the Department implements the new payment
13 methodology, the nursing component rate per patient day for
14 the facility shall be adjusted.

15 (C) Notwithstanding paragraphs (A) and (B), the
16 nursing component rate per patient day for the facility
17 shall be adjusted subject to appropriations provided by the
18 General Assembly.

19 For facilities licensed by the Department of Public Health
20 under the Nursing Home Care Act as Intermediate Care for the
21 Developmentally Disabled facilities or Long Term Care for Under
22 Age 22 facilities, the rates taking effect on March 1, 2001
23 shall include a statewide increase of 7.85%, as defined by the
24 Department.

25 Notwithstanding any other provision of this Section, for
26 facilities licensed by the Department of Public Health under

1 the Nursing Home Care Act as skilled nursing facilities or
2 intermediate care facilities, except facilities participating
3 in the Department's demonstration program pursuant to the
4 provisions of Title 77, Part 300, Subpart T of the Illinois
5 Administrative Code, the numerator of the ratio used by the
6 Department of Healthcare and Family Services to compute the
7 rate payable under this Section using the Minimum Data Set
8 (MDS) methodology shall incorporate the following annual
9 amounts as the additional funds appropriated to the Department
10 specifically to pay for rates based on the MDS nursing
11 component methodology in excess of the funding in effect on
12 December 31, 2006:

13 (i) For rates taking effect January 1, 2007,
14 \$60,000,000.

15 (ii) For rates taking effect January 1, 2008,
16 \$110,000,000.

17 (iii) For rates taking effect January 1, 2009,
18 \$194,000,000.

19 (iv) For rates taking effect April 1, 2011, or the
20 first day of the month that begins at least 45 days after
21 the effective date of this amendatory Act of the 96th
22 General Assembly, \$416,500,000 or an amount as may be
23 necessary to complete the transition to the MDS methodology
24 for the nursing component of the rate. Increased payments
25 under this item (iv) are not due and payable, however,
26 until (i) the methodologies described in this paragraph are

1 approved by the federal government in an appropriate State
2 Plan amendment and (ii) the assessment imposed by Section
3 5B-2 of this Code is determined to be a permissible tax
4 under Title XIX of the Social Security Act.

5 Notwithstanding any other provision of this Section, for
6 facilities licensed by the Department of Public Health under
7 the Nursing Home Care Act as skilled nursing facilities or
8 intermediate care facilities, the support component of the
9 rates taking effect on January 1, 2008 shall be computed using
10 the most recent cost reports on file with the Department of
11 Healthcare and Family Services no later than April 1, 2005,
12 updated for inflation to January 1, 2006.

13 For facilities licensed by the Department of Public Health
14 under the Nursing Home Care Act as Intermediate Care for the
15 Developmentally Disabled facilities or Long Term Care for Under
16 Age 22 facilities, the rates taking effect on April 1, 2002
17 shall include a statewide increase of 2.0%, as defined by the
18 Department. This increase terminates on July 1, 2002; beginning
19 July 1, 2002 these rates are reduced to the level of the rates
20 in effect on March 31, 2002, as defined by the Department.

21 For facilities licensed by the Department of Public Health
22 under the Nursing Home Care Act as skilled nursing facilities
23 or intermediate care facilities, the rates taking effect on
24 July 1, 2001 shall be computed using the most recent cost
25 reports on file with the Department of Public Aid no later than
26 April 1, 2000, updated for inflation to January 1, 2001. For

1 rates effective July 1, 2001 only, rates shall be the greater
2 of the rate computed for July 1, 2001 or the rate effective on
3 June 30, 2001.

4 Notwithstanding any other provision of this Section, for
5 facilities licensed by the Department of Public Health under
6 the Nursing Home Care Act as skilled nursing facilities or
7 intermediate care facilities, the Illinois Department shall
8 determine by rule the rates taking effect on July 1, 2002,
9 which shall be 5.9% less than the rates in effect on June 30,
10 2002.

11 Notwithstanding any other provision of this Section, for
12 facilities licensed by the Department of Public Health under
13 the Nursing Home Care Act as skilled nursing facilities or
14 intermediate care facilities, if the payment methodologies
15 required under Section 5A-12 and the waiver granted under 42
16 CFR 433.68 are approved by the United States Centers for
17 Medicare and Medicaid Services, the rates taking effect on July
18 1, 2004 shall be 3.0% greater than the rates in effect on June
19 30, 2004. These rates shall take effect only upon approval and
20 implementation of the payment methodologies required under
21 Section 5A-12.

22 Notwithstanding any other provisions of this Section, for
23 facilities licensed by the Department of Public Health under
24 the Nursing Home Care Act as skilled nursing facilities or
25 intermediate care facilities, the rates taking effect on
26 January 1, 2005 shall be 3% more than the rates in effect on

1 December 31, 2004.

2 Notwithstanding any other provision of this Section, for
3 facilities licensed by the Department of Public Health under
4 the Nursing Home Care Act as skilled nursing facilities or
5 intermediate care facilities, effective January 1, 2009, the
6 per diem support component of the rates effective on January 1,
7 2008, computed using the most recent cost reports on file with
8 the Department of Healthcare and Family Services no later than
9 April 1, 2005, updated for inflation to January 1, 2006, shall
10 be increased to the amount that would have been derived using
11 standard Department of Healthcare and Family Services methods,
12 procedures, and inflators.

13 Notwithstanding any other provisions of this Section, for
14 facilities licensed by the Department of Public Health under
15 the Nursing Home Care Act as intermediate care facilities that
16 are federally defined as Institutions for Mental Disease, or
17 facilities licensed by the Department of Public Health under
18 the Specialized Mental Health Rehabilitation ~~Facilities~~ Act, a
19 socio-development component rate equal to 6.6% of the
20 facility's nursing component rate as of January 1, 2006 shall
21 be established and paid effective July 1, 2006. The
22 socio-development component of the rate shall be increased by a
23 factor of 2.53 on the first day of the month that begins at
24 least 45 days after January 11, 2008 (the effective date of
25 Public Act 95-707). As of August 1, 2008, the socio-development
26 component rate shall be equal to 6.6% of the facility's nursing

1 component rate as of January 1, 2006, multiplied by a factor of
2 3.53. For services provided on or after April 1, 2011, or the
3 first day of the month that begins at least 45 days after the
4 effective date of this amendatory Act of the 96th General
5 Assembly, whichever is later, the Illinois Department may by
6 rule adjust these socio-development component rates, and may
7 use different adjustment methodologies for those facilities
8 participating, and those not participating, in the Illinois
9 Department's demonstration program pursuant to the provisions
10 of Title 77, Part 300, Subpart T of the Illinois Administrative
11 Code, but in no case may such rates be diminished below those
12 in effect on August 1, 2008.

13 For facilities licensed by the Department of Public Health
14 under the Nursing Home Care Act as Intermediate Care for the
15 Developmentally Disabled facilities or as long-term care
16 facilities for residents under 22 years of age, the rates
17 taking effect on July 1, 2003 shall include a statewide
18 increase of 4%, as defined by the Department.

19 For facilities licensed by the Department of Public Health
20 under the Nursing Home Care Act as Intermediate Care for the
21 Developmentally Disabled facilities or Long Term Care for Under
22 Age 22 facilities, the rates taking effect on the first day of
23 the month that begins at least 45 days after the effective date
24 of this amendatory Act of the 95th General Assembly shall
25 include a statewide increase of 2.5%, as defined by the
26 Department.

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

13 Rates established effective each July 1 shall govern
14 payment for services rendered throughout that fiscal year,
15 except that rates established on July 1, 1996 shall be
16 increased by 6.8% for services provided on or after January 1,
17 1997. Such rates will be based upon the rates calculated for
18 the year beginning July 1, 1990, and for subsequent years
19 thereafter until June 30, 2001 shall be based on the facility
20 cost reports for the facility fiscal year ending at any point
21 in time during the previous calendar year, updated to the
22 midpoint of the rate year. The cost report shall be on file
23 with the Department no later than April 1 of the current rate
24 year. Should the cost report not be on file by April 1, the
25 Department shall base the rate on the latest cost report filed
26 by each skilled care facility and intermediate care facility,

1 updated to the midpoint of the current rate year. In
2 determining rates for services rendered on and after July 1,
3 1985, fixed time shall not be computed at less than zero. The
4 Department shall not make any alterations of regulations which
5 would reduce any component of the Medicaid rate to a level
6 below what that component would have been utilizing in the rate
7 effective on July 1, 1984.

8 (2) Shall take into account the actual costs incurred by
9 facilities in providing services for recipients of skilled
10 nursing and intermediate care services under the medical
11 assistance program.

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

14 (4) Shall take into account the actual costs incurred by
15 facilities in meeting licensing and certification standards
16 imposed and prescribed by the State of Illinois, any of its
17 political subdivisions or municipalities and by the U.S.
18 Department of Health and Human Services pursuant to Title XIX
19 of the Social Security Act.

20 The Department of Healthcare and Family Services shall
21 develop precise standards for payments to reimburse nursing
22 facilities for any utilization of appropriate rehabilitative
23 personnel for the provision of rehabilitative services which is
24 authorized by federal regulations, including reimbursement for
25 services provided by qualified therapists or qualified
26 assistants, and which is in accordance with accepted

1 professional practices. Reimbursement also may be made for
2 utilization of other supportive personnel under appropriate
3 supervision.

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

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

24 ~~(6)~~ No payment increase under this Section for the MDS
25 methodology, exceptional care residents, or the
26 socio-development component rate established by Public Act

1 96-1530 of the 96th General Assembly and funded by the
2 assessment imposed under Section 5B-2 of this Code shall be due
3 and payable until after the Department notifies the long-term
4 care providers, in writing, that the payment methodologies to
5 long-term care providers required under this Section have been
6 approved by the Centers for Medicare and Medicaid Services of
7 the U.S. Department of Health and Human Services and the
8 waivers under 42 CFR 433.68 for the assessment imposed by this
9 Section, if necessary, have been granted by the Centers for
10 Medicare and Medicaid Services of the U.S. Department of Health
11 and Human Services. Upon notification to the Department of
12 approval of the payment methodologies required under this
13 Section and the waivers granted under 42 CFR 433.68, all
14 increased payments otherwise due under this Section prior to
15 the date of notification shall be due and payable within 90
16 days of the date federal approval is received.

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

22 (Source: P.A. 96-45, eff. 7-15-09; 96-339, eff. 7-1-10; 96-959,
23 eff. 7-1-10; 96-1000, eff. 7-2-10; 96-1530, eff. 2-16-11;
24 97-10, eff. 6-14-11; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12;
25 97-584, eff. 8-26-11; revised 10-4-11.)

1 (305 ILCS 5/5-5.4e)

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

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

1 Section 5-5e.

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

3 (305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

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

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

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

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

17 (3) Ancillary Services, with the payment rate being
18 developed for each individual type of service. Payment
19 shall be made only when authorized under procedures
20 developed by the Department of Healthcare and Family
21 Services.

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

25 (5) Real Estate Taxes, with the cost of this component

1 being determined by taking into account the figures
2 contained in the most currently available cost reports
3 (with no imposition of maximums) updated to the midpoint of
4 the current rate year for long term care services rendered
5 between July 1, 1984 and June 30, 1985, and with the cost
6 of this component being determined by taking into account
7 the actual 1983 taxes for which the nursing homes were
8 assessed (with no imposition of maximums) updated to the
9 midpoint of the current rate year for long term care
10 services rendered between July 1, 1985 and June 30, 1986.

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

15 (1) Reasonable capital cost determined by utilizing
16 incurred interest rate and the current value of the
17 investment, including land, utilizing composite rates, or
18 by utilizing such other reasonable cost related methods
19 determined by the Department. However, beginning with the
20 rate reimbursement period effective July 1, 1987, the
21 Department shall be prohibited from establishing,
22 including, and implementing any depreciation factor in
23 calculating the capital cost element.

24 (2) Profit, with the actual amount being produced and
25 accruing to the providers in the form of a return on their
26 total investment, on the basis of their ability to

1 economically and efficiently deliver a type of service. The
2 method of payment may assure the opportunity for a profit,
3 but shall not guarantee or establish a specific amount as a
4 cost.

5 (c) The Illinois Department may implement the amendatory
6 changes to this Section made by this amendatory Act of 1991
7 through the use of emergency rules in accordance with the
8 provisions of Section 5.02 of the Illinois Administrative
9 Procedure Act. For purposes of the Illinois Administrative
10 Procedure Act, the adoption of rules to implement the
11 amendatory changes to this Section made by this amendatory Act
12 of 1991 shall be deemed an emergency and necessary for the
13 public interest, safety and welfare.

14 (d) No later than January 1, 2001, the Department of Public
15 Aid shall file with the Joint Committee on Administrative
16 Rules, pursuant to the Illinois Administrative Procedure Act, a
17 proposed rule, or a proposed amendment to an existing rule,
18 regarding payment for appropriate services, including
19 assessment, care planning, discharge planning, and treatment
20 provided by nursing facilities to residents who have a serious
21 mental illness.

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

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

3 (305 ILCS 5/5-5.8b) (from Ch. 23, par. 5-5.8b)

4 Sec. 5-5.8b. Payment to Campus Facilities. There is hereby
5 established a separate payment category for campus facilities.
6 A "campus facility" is defined as an entity which consists of a
7 long term care facility (or group of facilities if the
8 facilities are on the same contiguous parcel of real estate)
9 which meets all of the following criteria as of May 1, 1987:
10 the entity provides care for both children and adults;
11 residents of the entity reside in three or more separate
12 buildings with congregate and small group living arrangements
13 on a single campus; the entity provides three or more separate
14 licensed levels of care; the entity (or a part of the entity)
15 is enrolled with the Department of Healthcare and Family
16 Services as a provider of long term care services and receives
17 payments from that Department; the entity (or a part of the
18 entity) receives funding from the Department of Human Services;
19 and the entity (or a part of the entity) holds a current
20 license as a child care institution issued by the Department of
21 Children and Family Services.

22 The Department of Healthcare and Family Services, the
23 Department of Human Services, and the Department of Children
24 and Family Services shall develop jointly a rate methodology or
25 methodologies for campus facilities. Such methodology or

1 methodologies may establish a single rate to be paid by all the
2 agencies, or a separate rate to be paid by each agency, or
3 separate components to be paid to different parts of the campus
4 facility. All campus facilities shall receive the same rate of
5 payment for similar services. Any methodology developed
6 pursuant to this section shall take into account the actual
7 costs to the facility of providing services to residents, and
8 shall be adequate to reimburse the allowable costs of a campus
9 facility which is economically and efficiently operated. Any
10 methodology shall be established on the basis of historical,
11 financial, and statistical data submitted by campus
12 facilities, and shall take into account the actual costs
13 incurred by campus facilities in providing services, and in
14 meeting licensing and certification standards imposed and
15 prescribed by the State of Illinois, any of its political
16 subdivisions or municipalities and by the United States
17 Department of Health and Human Services. Rates may be
18 established on a prospective or retrospective basis. Any
19 methodology shall provide reimbursement for appropriate
20 payment elements, including the following: standard services,
21 patient services, real estate taxes, and capital costs.

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

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

2 (305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

3 Sec. 5-5.12. Pharmacy payments.

4 (a) Every request submitted by a pharmacy for reimbursement
5 under this Article for prescription drugs provided to a
6 recipient of aid under this Article shall include the name of
7 the prescriber or an acceptable identification number as
8 established by the Department.

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

19 (c) (Blank).

20 ~~(d) The Department shall not impose requirements for prior~~
21 ~~approval based on a preferred drug list for anti-retroviral,~~
22 ~~anti-hemophilic factor concentrates, or any atypical~~
23 ~~antipsychotics, conventional antipsychotics, or~~
24 ~~anticonvulsants used for the treatment of serious mental~~
25 ~~illnesses until 30 days after it has conducted a study of the~~

1 ~~impact of such requirements on patient care and submitted a~~
2 ~~report to the Speaker of the House of Representatives and the~~
3 ~~President of the Senate.~~ The Department shall review
4 utilization of narcotic medications in the medical assistance
5 program and impose utilization controls that protect against
6 abuse.

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

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

1 consult with the Department of Human Services Division of
2 Mental Health in developing a protocol and criteria for
3 deciding whether to grant such prior approval.

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

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

12 (h) Effective July 1, 2011, the Department shall
13 discontinue coverage of select over-the-counter drugs,
14 including analgesics and cough and cold and allergy
15 medications.

16 (h-5) On and after July 1, 2012, the Department shall
17 impose utilization controls, including, but not limited to,
18 prior approval on specialty drugs, oncolytic drugs, drugs for
19 the treatment of HIV or AIDS, immunosuppressant drugs, and
20 biological products in order to maximize savings on these
21 drugs. The Department may adjust payment methodologies for
22 non-pharmacy billed drugs in order to incentivize the selection
23 of lower-cost drugs. For drugs for the treatment of AIDS, the
24 Department shall take into consideration the potential for
25 non-adherence by certain populations, and shall develop
26 protocols with organizations or providers primarily serving

1 those with HIV/AIDS, as long as such measures intend to
2 maintain cost neutrality with other utilization management
3 controls such as prior approval. For hemophilia, the Department
4 shall develop a program of utilization review and control which
5 may include, in the discretion of the Department, prior
6 approvals. The Department may impose special standards on
7 providers that dispense blood factors which shall include, in
8 the discretion of the Department, staff training and education;
9 patient outreach and education; case management; in-home
10 patient assessments; assay management; maintenance of stock;
11 emergency dispensing timeframes; data collection and
12 reporting; dispensing of supplies related to blood factor
13 infusions; cold chain management and packaging practices; care
14 coordination; product recalls; and emergency clinical
15 consultation. The Department may require patients to receive a
16 comprehensive examination annually at an appropriate provider
17 in order to be eligible to continue to receive blood factor.

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

23 ~~(i) (Blank). The Department shall seek any necessary waiver~~
24 ~~from the federal government in order to establish a program~~
25 ~~limiting the pharmacies eligible to dispense specialty drugs~~
26 ~~and shall issue a Request for Proposals in order to maximize~~

1 ~~savings on these drugs. The Department shall by rule establish~~
2 ~~the drugs required to be dispensed in this program.~~

3 (j) On and after July 1, 2012, the Department shall impose
4 limitations on prescription drugs such that the Department
5 shall not provide reimbursement for more than 4 prescriptions,
6 including 3 brand name prescriptions, for distinct drugs in a
7 30-day period, unless prior approval is received for all
8 prescriptions in excess of the 4-prescription limit. Drugs in
9 the following therapeutic classes shall not be subject to prior
10 approval as a result of the 4-prescription limit:
11 immunosuppressant drugs, oncolytic drugs, and anti-retroviral
12 drugs.

13 (k) No medication therapy management program implemented
14 by the Department shall be contrary to the provisions of the
15 Pharmacy Practice Act.

16 (l) Any provider enrolled with the Department that bills
17 the Department for outpatient drugs and is eligible to enroll
18 in the federal Drug Pricing Program under Section 340B of the
19 federal Public Health Services Act shall enroll in that
20 program. No entity participating in the federal Drug Pricing
21 Program under Section 340B of the federal Public Health
22 Services Act may exclude Medicaid from their participation in
23 that program, although the Department may exclude entities
24 defined in Section 1905(1)(2)(B) of the Social Security Act
25 from this requirement.

26 (Source: P.A. 96-1269, eff. 7-26-10; 96-1372, eff. 7-29-10;

1 96-1501, eff. 1-25-11; 97-38, eff. 6-28-11; 97-74, eff.
2 6-30-11; 97-333, eff. 8-12-11; 97-426, eff. 1-1-12; revised
3 10-4-11.)

4 (305 ILCS 5/5-5.17) (from Ch. 23, par. 5-5.17)

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

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

1 Section 5-5e.

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

3 (305 ILCS 5/5-5.20)

4 Sec. 5-5.20. Clinic payments. For services provided by
5 federally qualified health centers as defined in Section 1905
6 (1) (2) (B) of the federal Social Security Act, on or after April
7 1, 1989, and as long as required by federal law, the Illinois
8 Department shall reimburse those health centers for those
9 services according to a prospective cost-reimbursement
10 methodology.

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

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

17 (305 ILCS 5/5-5.23)

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

19 (a) The Department of Healthcare and Family Services, by
20 rule, shall require the screening and assessment of a child
21 prior to any Medicaid-funded admission to an inpatient hospital
22 for psychiatric services to be funded by Medicaid. The
23 screening and assessment shall include a determination of the
24 appropriateness and availability of out-patient support

1 services for necessary treatment. The Department, by rule,
2 shall establish methods and standards of payment for the
3 screening, assessment, and necessary alternative support
4 services.

5 (b) The Department of Healthcare and Family Services, to
6 the extent allowable under federal law, shall secure federal
7 financial participation for Individual Care Grant expenditures
8 made by the Department of Human Services for the Medicaid
9 optional service authorized under Section 1905(h) of the
10 federal Social Security Act, pursuant to the provisions of
11 Section 7.1 of the Mental Health and Developmental Disabilities
12 Administrative Act.

13 (c) The Department of Healthcare and Family Services shall
14 work jointly with the Department of Human Services to implement
15 subsections (a) and (b).

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

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

22 (305 ILCS 5/5-5.24)

23 Sec. 5-5.24. Prenatal and perinatal care. The Department of
24 Healthcare and Family Services may provide reimbursement under
25 this Article for all prenatal and perinatal health care

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

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

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

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

6 (305 ILCS 5/5-5.25)

7 Sec. 5-5.25. Access to psychiatric mental health services.
8 The General Assembly finds that providing access to psychiatric
9 mental health services in a timely manner will improve the
10 quality of life for persons suffering from mental illness and
11 will contain health care costs by avoiding the need for more
12 costly inpatient hospitalization. The Department of Healthcare
13 and Family Services shall reimburse psychiatrists and
14 federally qualified health centers as defined in Section
15 1905(1)(2)(B) of the federal Social Security Act for mental
16 health services provided by psychiatrists, as authorized by
17 Illinois law, to recipients via telepsychiatry. The
18 Department, by rule, shall establish (i) criteria for such
19 services to be reimbursed, including appropriate facilities
20 and equipment to be used at both sites and requirements for a
21 physician or other licensed health care professional to be
22 present at the site where the patient is located, and (ii) a
23 method to reimburse providers for mental health services
24 provided by telepsychiatry.

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

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

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

6 (305 ILCS 5/5-5e new)

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

8 (a) Rates or payments for services in effect on June 30,
9 2012 shall be adjusted and services shall be affected as
10 required by any other provision of this amendatory Act of the
11 97th General Assembly. In addition, the Department shall do the
12 following:

13 (1) Delink the per diem rate paid for supportive living
14 facility services from the per diem rate paid for nursing
15 facility services, effective for services provided on or
16 after May 1, 2011.

17 (2) Cease payment for bed reserves in nursing
18 facilities, specialized mental health rehabilitation
19 facilities, and, except in the instance of residents who
20 are under 21 years of age, intermediate care facilities for
21 persons with developmental disabilities.

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

25 (b) After the application of subsection (a),

1 notwithstanding any other provision of this Code to the
2 contrary and to the extent permitted by federal law, on and
3 after July 1, 2012, the rates of reimbursement for services and
4 other payments provided under this Code shall further be
5 reduced as follows:

6 (1) Rates or payments for physician services, dental
7 services, or community health center services reimbursed
8 through an encounter rate, and services provided under the
9 Medicaid Rehabilitation Option of the Illinois Title XIX
10 State Plan shall not be further reduced.

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

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

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

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

26 (6) Rates or payments for services delivered by long

1 term care facilities licensed under the ID/DD Community
2 Care Act and developmental training services shall not be
3 further reduced.

4 (7) Rates or payments for services provided under
5 capitation rates shall be adjusted taking into
6 consideration the rates reduction and covered services
7 required by this amendatory Act of the 97th General
8 Assembly.

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

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

17 (c) Any assessment imposed by this Code shall continue and
18 nothing in this Section shall be construed to cause it to
19 cease.

20 (305 ILCS 5/5-5e.1 new)

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

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

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

25 (2) is a disproportionate share hospital, as described

1 in Section 1923 of the federal Social Security Act, as
2 determined by the Department; and

3 (3) meets one of the following:

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

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

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

8 (1) "Charity percent" means the ratio of (i) the
9 hospital's charity charges for services provided to
10 individuals without health insurance or another source of
11 third party coverage to (ii) the Illinois total hospital
12 charges, each as reported on the hospital's OBRA form.

13 (2) "MIUR" means Medicaid Inpatient Utilization Rate
14 and is defined as a fraction, the numerator of which is the
15 number of a hospital's inpatient days provided in the
16 hospital's fiscal year ending 3 years prior to the rate
17 year, to patients who, for such days, were eligible for
18 Medicaid under Title XIX of the federal Social Security
19 Act, 42 USC 1396a et seq., and the denominator of which is
20 the total number of the hospital's inpatient days in that
21 same period.

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

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

26 (c) For the 27-month period beginning July 1, 2012, a

1 hospital that would have qualified for the rate year beginning
2 October 1, 2011, shall be a Safety-Net Hospital.

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

7 (e) The Department may promulgate rules in order to
8 implement this Section.

9 (305 ILCS 5/5-5f new)

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

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

18 (b) The Department shall place the following limitations on
19 services: (i) the Department shall limit adult eyeglasses to
20 one pair every 2 years; (ii) the Department shall set an annual
21 limit of a maximum of 20 visits for each of the following
22 services: adult speech, hearing, and language therapy
23 services, adult occupational therapy services, and physical
24 therapy services; (iii) the Department shall limit podiatry
25 services to individuals with diabetes; (iv) the Department

1 shall pay for caesarean sections at the normal vaginal delivery
2 rate unless a caesarean section was medically necessary; (v)
3 the Department shall limit adult dental services to
4 emergencies; and (vi) effective July 1, 2012, the Department
5 shall place limitations and require concurrent review on every
6 inpatient detoxification stay to prevent repeat admissions to
7 any hospital for detoxification within 60 days of a previous
8 inpatient detoxification stay. The Department shall convene a
9 workgroup of hospitals, substance abuse providers, care
10 coordination entities, managed care plans, and other
11 stakeholders to develop recommendations for quality standards,
12 diversion to other settings, and admission criteria for
13 patients who need inpatient detoxification.

14 (c) The Department shall require prior approval of the
15 following services: wheelchair repairs, regardless of the cost
16 of the repairs, coronary artery bypass graft, and bariatric
17 surgery consistent with Medicare standards concerning patient
18 responsibility. The wholesale cost of power wheelchairs shall
19 be actual acquisition cost including all discounts.

20 (d) The Department shall establish benchmarks for
21 hospitals to measure and align payments to reduce potentially
22 preventable hospital readmissions, inpatient complications,
23 and unnecessary emergency room visits. In doing so, the
24 Department shall consider items, including, but not limited to,
25 historic and current acuity of care and historic and current
26 trends in readmission. The Department shall publish

1 provider-specific historical readmission data and anticipated
2 potentially preventable targets 60 days prior to the start of
3 the program. In the instance of readmissions, the Department
4 shall adopt policies and rates of reimbursement for services
5 and other payments provided under this Code to ensure that, by
6 June 30, 2013, expenditures to hospitals are reduced by, at a
7 minimum, \$40,000,000.

8 (e) The Department shall establish utilization controls
9 for the hospice program such that it shall not pay for other
10 care services when an individual is in hospice.

11 (f) For home health services, the Department shall require
12 Medicare certification of providers participating in the
13 program, implement the Medicare face-to-face encounter rule,
14 and limit services to post-hospitalization. The Department
15 shall require providers to implement auditable electronic
16 service verification based on global positioning systems or
17 other cost-effective technology.

18 (g) For the Home Services Program operated by the
19 Department of Human Services and the Community Care Program
20 operated by the Department on Aging, the Department of Human
21 Services, in cooperation with the Department on Aging, shall
22 implement an electronic service verification based on global
23 positioning systems or other cost-effective technology.

24 (h) The Department shall not pay for hospital admissions
25 when the claim indicates a hospital acquired condition that
26 would cause Medicare to reduce its payment on the claim had the

1 claim been submitted to Medicare, nor shall the Department pay
2 for hospital admissions where a Medicare identified "never
3 event" occurred.

4 (i) The Department shall implement cost savings
5 initiatives for advanced imaging services, cardiac imaging
6 services, pain management services, and back surgery. Such
7 initiatives shall be designed to achieve annual costs savings.

8 (305 ILCS 5/5-16.7)

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

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

18 (Source: P.A. 89-513, eff. 9-15-96; 90-14, eff. 7-1-97.)

19 (305 ILCS 5/5-16.7a)

20 Sec. 5-16.7a. Reimbursement for epidural anesthesia
21 services. In addition to other procedures authorized by the
22 Department under this Code, the Department shall provide
23 reimbursement to medical providers for epidural anesthesia
24 services when ordered by the attending practitioner at the time

1 of delivery.

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

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

8 (305 ILCS 5/5-16.8)

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

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

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

22 (305 ILCS 5/5-16.9)

23 Sec. 5-16.9. Woman's health care provider. The medical
24 assistance program is subject to the provisions of Section 356r

1 of the Illinois Insurance Code. The Illinois Department shall
2 adopt rules to implement the requirements of Section 356r of
3 the Illinois Insurance Code in the medical assistance program
4 including managed care components.

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

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

11 (305 ILCS 5/5-17) (from Ch. 23, par. 5-17)

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

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

14 (A) That while hospitals have traditionally
15 provided charitable care to indigent patients, this
16 burden is not equally borne by all hospitals operating
17 in this State. Some hospitals continue to provide
18 significant amounts of care to low-income persons
19 while others provide very little such care; and

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

24 (2) To help expand the availability of hospital care
25 for all citizens of this State, it is the policy of the

1 State to implement programs that more equitably distribute
2 the burden of providing hospital care to Illinois'
3 low-income population and that improve access to health
4 care in Illinois.

5 (3) The Illinois Department may develop and implement a
6 program that lessens the burden of providing hospital care
7 to Illinois' low-income population, taking into account
8 the costs that must be incurred by hospitals providing
9 significant amounts of care to low-income persons, and may
10 develop adjustments to increase rates to improve access to
11 health care in Illinois. The Illinois Department shall
12 prescribe by rule the criteria, standards and procedures
13 for effecting such adjustments in the rates of hospital
14 payments for services provided to eligible low-income
15 persons (under Articles V, VI and VII of this Code) under
16 this Article.

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

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

22 (2) provide data and reports on the provision of
23 uncompensated care.

24 (c) From the effective date of this amendatory Act of 1992
25 until July 1, 1992, nothing in this Section 5-17 shall be
26 construed as creating a private right of action on behalf of

1 any individual.

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

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

8 (305 ILCS 5/5-19) (from Ch. 23, par. 5-19)

9 Sec. 5-19. Healthy Kids Program.

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

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

24 (c) Healthy Kids Examinations. The Illinois Department
25 shall consider any examination of a child eligible for the

1 Healthy Kids services provided by a medical provider meeting
2 the requirements and complying with the rules and regulations
3 of the Illinois Department to be reimbursed as a Healthy Kids
4 examination.

5 (d) Medical Screening Examinations.

6 (1) The Illinois Department shall insure Medicaid
7 coverage for periodic health, vision, hearing, and dental
8 screenings for children eligible for Healthy Kids services
9 scheduled from a child's birth up until the child turns 21
10 years. The Illinois Department shall pay for vision,
11 hearing, dental and health screening examinations for any
12 child eligible for Healthy Kids services by qualified
13 providers at intervals established by Department rules.

14 (2) The Illinois Department shall pay for an
15 interperiodic health, vision, hearing, or dental screening
16 examination for any child eligible for Healthy Kids
17 services whenever an examination is:

18 (A) requested by a child's parent, guardian, or
19 custodian, or is determined to be necessary or
20 appropriate by social services, developmental, health,
21 or educational personnel; or

22 (B) necessary for enrollment in school; or

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

25 (D) necessary for placement in a licensed child
26 welfare facility, including a foster home, group home

1 or child care institution; or

2 (E) necessary for attendance at a camping program;

3 or

4 (F) necessary for participation in an organized
5 athletic program; or

6 (G) necessary for enrollment in an early childhood
7 education program recognized by the Illinois State
8 Board of Education; or

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

11 (I) deemed appropriate by the Illinois Department.

12 (e) Minimum Screening Protocols For Periodic Health
13 Screening Examinations. Health Screening Examinations must
14 include the following services:

15 (1) Comprehensive Health and Development Assessment
16 including:

17 (A) Development/Mental Health/Psychosocial
18 Assessment; and

19 (B) Assessment of nutritional status including
20 tests for iron deficiency and anemia for children at
21 the following ages: 9 months, 2 years, 8 years, and 18
22 years;

23 (2) Comprehensive unclothed physical exam;

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

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

3 (A) Anemia test.

4 (B) Sickle cell test.

5 (C) Tuberculin test at 12 months of age and every
6 1-2 years thereafter unless the treating health care
7 professional determines that testing is medically
8 contraindicated.

9 (D) Other -- The Illinois Department shall insure
10 that testing for HIV, drug exposure, and sexually
11 transmitted diseases is provided for as clinically
12 indicated.

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

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

20 (7) Hearing Screening. The Illinois Department shall
21 require providers to provide hearing screenings consistent
22 with those set forth in the Department of Public Health's
23 Administrative Rules.

24 (8) Dental Screening. The Illinois Department shall
25 require providers to provide dental screenings consistent
26 with those set forth in the Department of Public Health's

1 Administrative Rules.

2 (f) Covered Medical Services. The Illinois Department
3 shall provide coverage for all necessary health care,
4 diagnostic services, treatment and other measures to correct or
5 ameliorate defects, physical and mental illnesses, and
6 conditions whether discovered by the screening services or not
7 for all children eligible for Medical Assistance under Article
8 V of this Code.

9 (g) Notice of Healthy Kids Services.

10 (1) The Illinois Department shall inform any child
11 eligible for Healthy Kids services and the child's family
12 about the benefits provided under the Healthy Kids Program,
13 including, but not limited to, the following: what services
14 are available under Healthy Kids, including discussion of
15 the periodicity schedules and immunization schedules, that
16 services are provided at no cost to eligible children, the
17 benefits of preventive health care, where the services are
18 available, how to obtain them, and that necessary
19 transportation and scheduling assistance is available.

20 (2) The Illinois Department shall widely disseminate
21 information regarding the availability of the Healthy Kids
22 Program throughout the State by outreach activities which
23 shall include, but not be limited to, (i) the development
24 of cooperation agreements with local school districts,
25 public health agencies, clinics, hospitals and other
26 health care providers, including developmental disability

1 and mental health providers, and with charities, to notify
2 the constituents of each of the Program and assist
3 individuals, as feasible, with applying for the Program,
4 (ii) using the media for public service announcements and
5 advertisements of the Program, and (iii) developing
6 posters advertising the Program for display in hospital and
7 clinic waiting rooms.

8 (3) The Illinois Department shall utilize accepted
9 methods for informing persons who are illiterate, blind,
10 deaf, or cannot understand the English language, including
11 but not limited to public services announcements and
12 advertisements in the foreign language media of radio,
13 television and newspapers.

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

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

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

21 (C) at least 20 days before the date of any
22 periodic health, vision, hearing, and dental
23 examination for any child eligible for Healthy Kids
24 services. Notice given under this subparagraph (C)
25 must state that a screening examination is due under
26 the periodicity schedules and must advise the eligible

1 child and his or her family that the Illinois
2 Department will provide assistance in scheduling an
3 appointment and arranging medical transportation.

4 (h) Data Collection. The Illinois Department shall collect
5 data in a usable form to track utilization of Healthy Kids
6 screening examinations by children eligible for Healthy Kids
7 services, including but not limited to data showing screening
8 examinations and immunizations received, a summary of
9 follow-up treatment received by children eligible for Healthy
10 Kids services and the number of children receiving dental,
11 hearing and vision services.

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

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

18 (305 ILCS 5/5-24)

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

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

22 (a) In this Section, "disease management programs and
23 services" means services administered to patients in order to
24 improve their overall health and to prevent clinical
25 exacerbations and complications, using cost-effective,

1 evidence-based practice guidelines and patient self-management
2 strategies. Disease management programs and services include
3 all of the following:

4 (1) A population identification process.

5 (2) Evidence-based or consensus-based clinical
6 practice guidelines, risk identification, and matching of
7 interventions with clinical need.

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

9 (4) Process and outcomes measurement, evaluation,
10 management, and reporting.

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

22 (c) The disease management programs and services pilot
23 project shall examine whether chronic disease management
24 programs and services for patients with specific chronic
25 conditions do any or all of the following:

26 (1) Improve the patient's overall health in a more

1 expeditious manner.

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

6 (d) In carrying out the pilot project, the Department of
7 Healthcare and Family Services shall examine all relevant
8 scientific literature and shall consult with health care
9 practitioners including, but not limited to, physicians,
10 surgeons, registered pharmacists, and registered nurses.

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

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

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

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

24 (Source: P.A. 95-331, eff. 8-21-07; 96-799, eff. 10-28-09.)

25 (305 ILCS 5/5-30)

1 Sec. 5-30. Care coordination.

2 (a) At least 50% of recipients eligible for comprehensive
3 medical benefits in all medical assistance programs or other
4 health benefit programs administered by the Department,
5 including the Children's Health Insurance Program Act and the
6 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
7 care coordination program by no later than January 1, 2015. For
8 purposes of this Section, "coordinated care" or "care
9 coordination" means delivery systems where recipients will
10 receive their care from providers who participate under
11 contract in integrated delivery systems that are responsible
12 for providing or arranging the majority of care, including
13 primary care physician services, referrals from primary care
14 physicians, diagnostic and treatment services, behavioral
15 health services, in-patient and outpatient hospital services,
16 dental services, and rehabilitation and long-term care
17 services. The Department shall designate or contract for such
18 integrated delivery systems (i) to ensure enrollees have a
19 choice of systems and of primary care providers within such
20 systems; (ii) to ensure that enrollees receive quality care in
21 a culturally and linguistically appropriate manner; and (iii)
22 to ensure that coordinated care programs meet the diverse needs
23 of enrollees with developmental, mental health, physical, and
24 age-related disabilities.

25 (b) Payment for such coordinated care shall be based on
26 arrangements where the State pays for performance related to

1 health care outcomes, the use of evidence-based practices, the
2 use of primary care delivered through comprehensive medical
3 homes, the use of electronic medical records, and the
4 appropriate exchange of health information electronically made
5 either on a capitated basis in which a fixed monthly premium
6 per recipient is paid and full financial risk is assumed for
7 the delivery of services, or through other risk-based payment
8 arrangements.

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

20 (d) The Department shall report to the General Assembly in
21 a separate part of its annual medical assistance program
22 report, beginning April, 2012 until April, 2016, on the
23 progress and implementation of the care coordination program
24 initiatives established by the provisions of this amendatory
25 Act of the 96th General Assembly. The Department shall include
26 in its April 2011 report a full analysis of federal laws or

1 regulations regarding upper payment limitations to providers
2 and the necessary revisions or adjustments in rate
3 methodologies and payments to providers under this Code that
4 would be necessary to implement coordinated care with full
5 financial risk by a party other than the Department.

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

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

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

18 (3) Payment for such coordinated care shall be based on
19 arrangements where the State pays for performance related
20 to mental health outcomes on a capitated basis in which a
21 fixed monthly premium per recipient is paid and full
22 financial risk is assumed for the delivery of services, or
23 through other risk-based payment arrangements such as
24 provider-based care coordination.

25 (4) The Department shall examine whether chronic
26 mental health management programs and services for

1 recipients with specific chronic mental health conditions
2 do any or all of the following:

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

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

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

15 (f) A hospital that is located in a county of the State in
16 which the Department mandates some or all of the beneficiaries
17 of the Medical Assistance Program residing in the county to
18 enroll in a Care Coordination Program, as set forth in Section
19 5-30 of this Code, shall not be eligible for any non-claims
20 based payments not mandated by Article V-A of this Code for
21 which it would otherwise be qualified to receive, unless the
22 hospital is a Coordinated Care Participating Hospital no later
23 that 60 days after the effective date of this amendatory Act of
24 the 97th General assembly or 60 days after the first mandatory
25 enrollment of a beneficiary in a Coordinated Care program. For
26 purposes of this subsection, "Coordinated Care Participating

1 Hospital" means a hospital that meets one of the following
2 criteria:

3 (1) The hospital has entered into a contract to provide
4 hospital services to enrollees of the care coordination
5 program.

6 (2) The hospital has not been offered a contract by a
7 care coordination plan that pays at least as much as the
8 Department would pay, on a fee-for-service-basis, not
9 including disproportionate share hospital adjustment
10 payments or any other supplemental adjustment or add-on
11 payment to the base fee-for-service rate.

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

13 (305 ILCS 5/5A-1) (from Ch. 23, par. 5A-1)

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

16 ~~"Adjusted gross hospital revenue" shall be determined~~
17 ~~separately for inpatient and outpatient services for each~~
18 ~~hospital conducted, operated or maintained by a hospital~~
19 ~~provider, and means the hospital provider's total gross~~
20 ~~revenues less: (i) gross revenue attributable to non-hospital~~
21 ~~based services including home dialysis services, durable~~
22 ~~medical equipment, ambulance services, outpatient clinics and~~
23 ~~any other non-hospital based services as determined by the~~
24 ~~Illinois Department by rule; and (ii) gross revenues~~
25 ~~attributable to the routine services provided to persons~~

1 ~~receiving skilled or intermediate long term care services~~
2 ~~within the meaning of Title XVIII or XIX of the Social Security~~
3 ~~Act; and (iii) Medicare gross revenue (excluding the Medicare~~
4 ~~gross revenue attributable to clauses (i) and (ii) of this~~
5 ~~paragraph and the Medicare gross revenue attributable to the~~
6 ~~routine services provided to patients in a psychiatric~~
7 ~~hospital, a rehabilitation hospital, a distinct part~~
8 ~~psychiatric unit, a distinct part rehabilitation unit, or swing~~
9 ~~beds). Adjusted gross hospital revenue shall be determined~~
10 ~~using the most recent data available from each hospital's 2003~~
11 ~~Medicare cost report as contained in the Healthcare Cost Report~~
12 ~~Information System file, for the quarter ending on December 31,~~
13 ~~2004, without regard to any subsequent adjustments or changes~~
14 ~~to such data. If a hospital's 2003 Medicare cost report is not~~
15 ~~contained in the Healthcare Cost Report Information System, the~~
16 ~~hospital provider shall furnish such cost report or the data~~
17 ~~necessary to determine its adjusted gross hospital revenue as~~
18 ~~required by rule by the Illinois Department.~~

19 "Fund" means the Hospital Provider Fund.

20 "Hospital" means an institution, place, building, or
21 agency located in this State that is subject to licensure by
22 the Illinois Department of Public Health under the Hospital
23 Licensing Act, whether public or private and whether organized
24 for profit or not-for-profit.

25 "Hospital provider" means a person licensed by the
26 Department of Public Health to conduct, operate, or maintain a

1 hospital, regardless of whether the person is a Medicaid
2 provider. For purposes of this paragraph, "person" means any
3 political subdivision of the State, municipal corporation,
4 individual, firm, partnership, corporation, company, limited
5 liability company, association, joint stock association, or
6 trust, or a receiver, executor, trustee, guardian, or other
7 representative appointed by order of any court.

8 "Medicare bed days" means, for each hospital, the sum of
9 the number of days that each bed was occupied by a patient who
10 was covered by Title XVIII of the Social Security Act,
11 excluding days attributable to the routine services provided to
12 persons receiving skilled or intermediate long term care
13 services. Medicare bed days shall be computed separately for
14 each hospital operated or maintained by a hospital provider.

15 "Occupied bed days" means the sum of the number of days
16 that each bed was occupied by a patient for all beds, excluding
17 days attributable to the routine services provided to persons
18 receiving skilled or intermediate long term care services.
19 Occupied bed days shall be computed separately for each
20 hospital operated or maintained by a hospital provider.

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

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

24 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

1 Sec. 5A-2. Assessment.

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

8 ~~For State fiscal years 2004 and 2005, the Department of~~
9 ~~Healthcare and Family Services shall use the number of occupied~~
10 ~~bed days as reported by each hospital on the Annual Survey of~~
11 ~~Hospitals conducted by the Department of Public Health to~~
12 ~~calculate the hospital's annual assessment. If the sum of a~~
13 ~~hospital's occupied bed days is not reported on the Annual~~
14 ~~Survey of Hospitals or if there are data errors in the reported~~
15 ~~sum of a hospital's occupied bed days as determined by the~~
16 ~~Department of Healthcare and Family Services (formerly~~
17 ~~Department of Public Aid), then the Department of Healthcare~~
18 ~~and Family Services may obtain the sum of occupied bed days~~
19 ~~from any source available, including, but not limited to,~~
20 ~~records maintained by the hospital provider, which may be~~
21 ~~inspected at all times during business hours of the day by the~~
22 ~~Department of Healthcare and Family Services or its duly~~
23 ~~authorized agents and employees.~~

24 ~~Subject to Sections 5A-3 and 5A-10, for the privilege of~~
25 ~~engaging in the occupation of hospital provider, beginning~~
26 ~~August 1, 2005, an annual assessment is imposed on each~~

1 ~~hospital provider for State fiscal years 2006, 2007, and 2008,~~
2 ~~in an amount equal to 2.5835% of the hospital provider's~~
3 ~~adjusted gross hospital revenue for inpatient services and~~
4 ~~2.5835% of the hospital provider's adjusted gross hospital~~
5 ~~revenue for outpatient services. If the hospital provider's~~
6 ~~adjusted gross hospital revenue is not available, then the~~
7 ~~Illinois Department may obtain the hospital provider's~~
8 ~~adjusted gross hospital revenue from any source available,~~
9 ~~including, but not limited to, records maintained by the~~
10 ~~hospital provider, which may be inspected at all times during~~
11 ~~business hours of the day by the Illinois Department or its~~
12 ~~duly authorized agents and employees.~~

13 Subject to Sections 5A-3 and 5A-10, for State fiscal years
14 2009 through 2014 and July 1, 2014 through December 31, 2014,
15 an annual assessment on inpatient services is imposed on each
16 hospital provider in an amount equal to \$218.38 multiplied by
17 the difference of the hospital's occupied bed days less the
18 hospital's Medicare bed days.

19 For State fiscal years 2009 through 2014 and after, a
20 hospital's occupied bed days and Medicare bed days shall be
21 determined using the most recent data available from each
22 hospital's 2005 Medicare cost report as contained in the
23 Healthcare Cost Report Information System file, for the quarter
24 ending on December 31, 2006, without regard to any subsequent
25 adjustments or changes to such data. If a hospital's 2005
26 Medicare cost report is not contained in the Healthcare Cost

1 Report Information System, then the Illinois Department may
2 obtain the hospital provider's occupied bed days and Medicare
3 bed days from any source available, including, but not limited
4 to, records maintained by the hospital provider, which may be
5 inspected at all times during business hours of the day by the
6 Illinois Department or its duly authorized agents and
7 employees.

8 (b) (Blank).

9 (c) (Blank).

10 (d) Notwithstanding any of the other provisions of this
11 Section, the Department is authorized, ~~during this 94th General~~
12 ~~Assembly,~~ to adopt rules to reduce the rate of any annual
13 assessment imposed under this Section, as authorized by Section
14 5-46.2 of the Illinois Administrative Procedure Act.

15 (e) Notwithstanding any other provision of this Section,
16 any plan providing for an assessment on a hospital provider as
17 a permissible tax under Title XIX of the federal Social
18 Security Act and Medicaid-eligible payments to hospital
19 providers from the revenues derived from that assessment shall
20 be reviewed by the Illinois Department of Healthcare and Family
21 Services, as the Single State Medicaid Agency required by
22 federal law, to determine whether those assessments and
23 hospital provider payments meet federal Medicaid standards. If
24 the Department determines that the elements of the plan may
25 meet federal Medicaid standards and a related State Medicaid
26 Plan Amendment is prepared in a manner and form suitable for

1 submission, that State Plan Amendment shall be submitted in a
2 timely manner for review by the Centers for Medicare and
3 Medicaid Services of the United States Department of Health and
4 Human Services and subject to approval by the Centers for
5 Medicare and Medicaid Services of the United States Department
6 of Health and Human Services. No such plan shall become
7 effective without approval by the Illinois General Assembly by
8 the enactment into law of related legislation. Notwithstanding
9 any other provision of this Section, the Department is
10 authorized to adopt rules to reduce the rate of any annual
11 assessment imposed under this Section. Any such rules may be
12 adopted by the Department under Section 5-50 of the Illinois
13 Administrative Procedure Act.

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

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

16 Sec. 5A-3. Exemptions.

17 (a) (Blank).

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

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

25 (b-5) (Blank).

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

8 (b-15) (Blank). ~~For State fiscal years 2004 and 2005, a~~
9 ~~hospital provider whose hospital is licensed by the Department~~
10 ~~of Public Health as a psychiatric hospital is exempt from the~~
11 ~~assessment imposed by Section 5A-2, unless the exemption is~~
12 ~~adjudged to be unconstitutional or otherwise invalid, in which~~
13 ~~case the hospital provider shall pay the assessment imposed by~~
14 ~~Section 5A-2.~~

15 (b-20) (Blank). ~~For State fiscal years 2004 and 2005, a~~
16 ~~hospital provider whose hospital is licensed by the Department~~
17 ~~of Public Health as a rehabilitation hospital is exempt from~~
18 ~~the assessment imposed by Section 5A-2, unless the exemption is~~
19 ~~adjudged to be unconstitutional or otherwise invalid, in which~~
20 ~~case the hospital provider shall pay the assessment imposed by~~
21 ~~Section 5A-2.~~

22 (b-25) (Blank). ~~For State fiscal years 2004 and 2005, a~~
23 ~~hospital provider whose hospital (i) is not a psychiatric~~
24 ~~hospital, rehabilitation hospital, or children's hospital and~~
25 ~~(ii) has an average length of inpatient stay greater than 25~~
26 ~~days is exempt from the assessment imposed by Section 5A-2,~~

1 ~~unless the exemption is adjudged to be unconstitutional or~~
2 ~~otherwise invalid, in which case the hospital provider shall~~
3 ~~pay the assessment imposed by Section 5A-2.~~

4 (c) (Blank).

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

6 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

7 Sec. 5A-4. Payment of assessment; penalty.

8 (a) ~~The~~ The ~~annual assessment imposed by Section 5A-2 for~~
9 ~~State fiscal year 2004 shall be due and payable on June 18 of~~
10 ~~the year. The assessment imposed by Section 5A-2 for State~~
11 ~~fiscal year 2005 shall be due and payable in quarterly~~
12 ~~installments, each equalling one-fourth of the assessment for~~
13 ~~the year, on July 19, October 19, January 18, and April 19 of~~
14 ~~the year. The assessment imposed by Section 5A-2 for State~~
15 ~~fiscal years 2006 through 2008 shall be due and payable in~~
16 ~~quarterly installments, each equaling one-fourth of the~~
17 ~~assessment for the year, on the fourteenth State business day~~
18 ~~of September, December, March, and May. Except as provided in~~
19 ~~subsection (a-5) of this Section, the assessment imposed by~~
20 Section 5A-2 for State fiscal year 2009 and each subsequent
21 State fiscal year shall be due and payable in monthly
22 installments, each equaling one-twelfth of the assessment for
23 the year, on the fourteenth State business day of each month.
24 No installment payment of an assessment imposed by Section 5A-2
25 shall be due and payable, however, until after the Comptroller

1 has issued the payments required under this Article. ~~:(i) the~~
2 ~~Department notifies the hospital provider, in writing, that the~~
3 ~~payment methodologies to hospitals required under Section~~
4 ~~5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is~~
5 ~~applicable for that fiscal year, have been approved by the~~
6 ~~Centers for Medicare and Medicaid Services of the U.S.~~
7 ~~Department of Health and Human Services and the waiver under 42~~
8 ~~CFR 433.68 for the assessment imposed by Section 5A-2, if~~
9 ~~necessary, has been granted by the Centers for Medicare and~~
10 ~~Medicaid Services of the U.S. Department of Health and Human~~
11 ~~Services; and (ii) the Comptroller has issued the payments~~
12 ~~required under Section 5A-12, Section 5A-12.1, or Section~~
13 ~~5A-12.2, whichever is applicable for that fiscal year. Upon~~
14 ~~notification to the Department of approval of the payment~~
15 ~~methodologies required under Section 5A-12, Section 5A-12.1,~~
16 ~~or Section 5A-12.2, whichever is applicable for that fiscal~~
17 ~~year, and the waiver granted under 42 CFR 433.68, all~~
18 ~~installments otherwise due under Section 5A-2 prior to the date~~
19 ~~of notification shall be due and payable to the Department upon~~
20 ~~written direction from the Department and issuance by the~~
21 ~~Comptroller of the payments required under Section 5A-12.1 or~~
22 ~~Section 5A-12.2, whichever is applicable for that fiscal year.~~

23 (a-5) The Illinois Department may, for the purpose of
24 maximizing federal revenue, accelerate the schedule upon which
25 assessment installments are due and payable by hospitals with a
26 payment ratio greater than or equal to one. Such acceleration

1 of due dates for payment of the assessment may be made only in
2 conjunction with a corresponding acceleration in access
3 payments identified in Section 5A-12.2 to the same hospitals.
4 For the purposes of this subsection (a-5), a hospital's payment
5 ratio is defined as the quotient obtained by dividing the total
6 payments for the State fiscal year, as authorized under Section
7 5A-12.2, by the total assessment for the State fiscal year
8 imposed under Section 5A-2.

9 (b) The Illinois Department is authorized to establish
10 delayed payment schedules for hospital providers that are
11 unable to make installment payments when due under this Section
12 due to financial difficulties, as determined by the Illinois
13 Department.

14 (c) If a hospital provider fails to pay the full amount of
15 an installment when due (including any extensions granted under
16 subsection (b)), there shall, unless waived by the Illinois
17 Department for reasonable cause, be added to the assessment
18 imposed by Section 5A-2 a penalty assessment equal to the
19 lesser of (i) 5% of the amount of the installment not paid on
20 or before the due date plus 5% of the portion thereof remaining
21 unpaid on the last day of each 30-day period thereafter or (ii)
22 100% of the installment amount not paid on or before the due
23 date. For purposes of this subsection, payments will be
24 credited first to unpaid installment amounts (rather than to
25 penalty or interest), beginning with the most delinquent
26 installments.

1 (d) Any assessment amount that is due and payable to the
2 Illinois Department more frequently than once per calendar
3 quarter shall be remitted to the Illinois Department by the
4 hospital provider by means of electronic funds transfer. The
5 Illinois Department may provide for remittance by other means
6 if (i) the amount due is less than \$10,000 or (ii) electronic
7 funds transfer is unavailable for this purpose.

8 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
9 96-821, eff. 11-20-09.)

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

11 Sec. 5A-5. Notice; penalty; maintenance of records.

12 (a) The Illinois Department ~~of Healthcare and Family~~
13 ~~Services~~ shall send a notice of assessment to every hospital
14 provider subject to assessment under this Article. The notice
15 of assessment shall notify the hospital of its assessment and
16 shall be sent after receipt by the Department of notification
17 from the Centers for Medicare and Medicaid Services of the U.S.
18 Department of Health and Human Services that the payment
19 methodologies required under this Article ~~Section 5A-12,~~
20 ~~Section 5A-12.1, or Section 5A-12.2, whichever is applicable~~
21 ~~for that fiscal year,~~ and, if necessary, the waiver granted
22 under 42 CFR 433.68 have been approved. The notice shall be on
23 a form prepared by the Illinois Department and shall state the
24 following:

25 (1) The name of the hospital provider.

1 (2) The address of the hospital provider's principal
2 place of business from which the provider engages in the
3 occupation of hospital provider in this State, and the name
4 and address of each hospital operated, conducted, or
5 maintained by the provider in this State.

6 (3) The occupied bed days, occupied bed days less
7 Medicare days, or adjusted gross hospital revenue of the
8 hospital provider (whichever is applicable), the amount of
9 assessment imposed under Section 5A-2 for the State fiscal
10 year for which the notice is sent, and the amount of each
11 installment to be paid during the State fiscal year.

12 (4) (Blank).

13 (5) Other reasonable information as determined by the
14 Illinois Department.

15 (b) If a hospital provider conducts, operates, or maintains
16 more than one hospital licensed by the Illinois Department of
17 Public Health, the provider shall pay the assessment for each
18 hospital separately.

19 (c) Notwithstanding any other provision in this Article, in
20 the case of a person who ceases to conduct, operate, or
21 maintain a hospital in respect of which the person is subject
22 to assessment under this Article as a hospital provider, the
23 assessment for the State fiscal year in which the cessation
24 occurs shall be adjusted by multiplying the assessment computed
25 under Section 5A-2 by a fraction, the numerator of which is the
26 number of days in the year during which the provider conducts,

1 operates, or maintains the hospital and the denominator of
2 which is 365. Immediately upon ceasing to conduct, operate, or
3 maintain a hospital, the person shall pay the assessment for
4 the year as so adjusted (to the extent not previously paid).

5 (d) Notwithstanding any other provision in this Article, a
6 provider who commences conducting, operating, or maintaining a
7 hospital, upon notice by the Illinois Department, shall pay the
8 assessment computed under Section 5A-2 and subsection (e) in
9 installments on the due dates stated in the notice and on the
10 regular installment due dates for the State fiscal year
11 occurring after the due dates of the initial notice.

12 ~~(e) Notwithstanding any other provision in this Article,~~
13 ~~for State fiscal years 2004 and 2005, in the case of a hospital~~
14 ~~provider that did not conduct, operate, or maintain a hospital~~
15 ~~throughout calendar year 2001, the assessment for that State~~
16 ~~fiscal year shall be computed on the basis of hypothetical~~
17 ~~occupied bed days for the full calendar year as determined by~~
18 ~~the Illinois Department. Notwithstanding any other provision~~
19 ~~in this Article, for State fiscal years 2006 through 2008, in~~
20 ~~the case of a hospital provider that did not conduct, operate,~~
21 ~~or maintain a hospital in 2003, the assessment for that State~~
22 ~~fiscal year shall be computed on the basis of hypothetical~~
23 ~~adjusted gross hospital revenue for the hospital's first full~~
24 ~~fiscal year as determined by the Illinois Department (which may~~
25 ~~be based on annualization of the provider's actual revenues for~~
26 ~~a portion of the year, or revenues of a comparable hospital for~~

1 ~~the year, including revenues realized by a prior provider of~~
2 ~~the same hospital during the year).~~ Notwithstanding any other
3 provision in this Article, for State fiscal years 2009 through
4 2015 ~~2014~~, in the case of a hospital provider that did not
5 conduct, operate, or maintain a hospital in 2005, the
6 assessment for that State fiscal year shall be computed on the
7 basis of hypothetical occupied bed days for the full calendar
8 year as determined by the Illinois Department.

9 (f) Every hospital provider subject to assessment under
10 this Article shall keep sufficient records to permit the
11 determination of adjusted gross hospital revenue for the
12 hospital's fiscal year. All such records shall be kept in the
13 English language and shall, at all times during regular
14 business hours of the day, be subject to inspection by the
15 Illinois Department or its duly authorized agents and
16 employees.

17 (g) The Illinois Department may, by rule, provide a
18 hospital provider a reasonable opportunity to request a
19 clarification or correction of any clerical or computational
20 errors contained in the calculation of its assessment, but such
21 corrections shall not extend to updating the cost report
22 information used to calculate the assessment.

23 (h) (Blank).

24 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
25 96-1530, eff. 2-16-11.)

1 (305 ILCS 5/5A-6) (from Ch. 23, par. 5A-6)

2 Sec. 5A-6. Disposition of proceeds. The Illinois
3 Department shall deposit ~~pay~~ all moneys received from hospital
4 providers under this Article into the Hospital Provider Fund.
5 Upon certification by the Illinois Department to the State
6 Comptroller of its intent to withhold payments from a provider
7 pursuant to ~~under~~ Section 5A-7(b), the State Comptroller shall
8 draw a warrant on the treasury or other fund held by the State
9 Treasurer, as appropriate. The warrant shall state the amount
10 for which the provider is entitled to a warrant, the amount of
11 the deduction, and the reason therefor and shall direct the
12 State Treasurer to pay the balance to the provider, all in
13 accordance with Section 10.05 of the State Comptroller Act. The
14 warrant also shall direct the State Treasurer to transfer the
15 amount of the deduction so ordered from the treasury or other
16 fund into the Hospital Provider Fund.

17 (Source: P.A. 87-861.)

18 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

24 (b) The Fund is created for the purpose of receiving moneys
25 in accordance with Section 5A-6 and disbursing moneys only for

1 the following purposes, notwithstanding any other provision of
2 law:

3 (1) For making payments to hospitals as required under
4 ~~Articles V, V-A, VI, and XIV~~ of this Code, under the
5 Children's Health Insurance Program Act, under the
6 Covering ALL KIDS Health Insurance Act, and under the Long
7 Term Acute Care Hospital Quality Improvement Transfer
8 Program Act. Senior Citizens and Disabled Persons Property
9 Tax Relief and Pharmaceutical Assistance Act.

10 (2) For the reimbursement of moneys collected by the
11 Illinois Department from hospitals or hospital providers
12 through error or mistake in performing the activities
13 authorized under ~~this Article and Article V~~ of this Code.

14 (3) For payment of administrative expenses incurred by
15 the Illinois Department or its agent in performing ~~the~~
16 activities under ~~authorized by~~ this Code, the Children's
17 Health Insurance Program Act, the Covering ALL KIDS Health
18 Insurance Act, and the Long Term Acute Care Hospital
19 Quality Improvement Transfer Program Act. Article.

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

23 (5) For making transfers, as those transfers are
24 authorized in the proceedings authorizing debt under the
25 Short Term Borrowing Act, but transfers made under this
26 paragraph (5) shall not exceed the principal amount of debt

1 issued in anticipation of the receipt by the State of
2 moneys to be deposited into the Fund.

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

9 (6.5) For making transfers to the Healthcare Provider
10 Relief Fund, except that transfers made under this
11 paragraph (6.5) shall not exceed \$60,000,000 in the
12 aggregate.

13 (7) For making transfers not exceeding the following
14 amounts, in each State fiscal year during which an
15 assessment is imposed pursuant to Section 5A-2, to the
16 following designated funds:

17	<u>Health and Human Services Medicaid Trust</u>	
18	<u>Fund</u>	<u>\$20,000,000</u>
19	<u>Long-Term Care Provider Fund</u>	<u>\$30,000,000</u>
20	<u>General Revenue Fund</u>	<u>\$80,000,000.</u>

21 Transfers under this paragraph shall be made within 7 days
22 after the payments have been received pursuant to the schedule
23 of payments provided in subsection (a) of Section 5A-4. ~~For~~
24 ~~State fiscal years 2004 and 2005 for making transfers to the~~
25 ~~Health and Human Services Medicaid Trust Fund, including 20% of~~
26 ~~the moneys received from hospital providers under Section 5A-4~~

1 ~~and transferred into the Hospital Provider Fund under Section~~
 2 ~~5A-6. For State fiscal year 2006 for making transfers to the~~
 3 ~~Health and Human Services Medicaid Trust Fund of up to~~
 4 ~~\$130,000,000 per year of the moneys received from hospital~~
 5 ~~providers under Section 5A-4 and transferred into the Hospital~~
 6 ~~Provider Fund under Section 5A-6. Transfers under this~~
 7 ~~paragraph shall be made within 7 days after the payments have~~
 8 ~~been received pursuant to the schedule of payments provided in~~
 9 ~~subsection (a) of Section 5A-4.~~

10 (7.5) (Blank). ~~For State fiscal year 2007 for making~~
 11 ~~transfers of the moneys received from hospital providers~~
 12 ~~under Section 5A-4 and transferred into the Hospital~~
 13 ~~Provider Fund under Section 5A-6 to the designated funds~~
 14 ~~not exceeding the following amounts in that State fiscal~~
 15 ~~year:~~

16 ~~Health and Human Services~~

17	Medicaid Trust Fund	\$20,000,000
18	Long Term Care Provider Fund	-\$30,000,000
19	General Revenue Fund	-\$80,000,000.

20 ~~Transfers under this paragraph shall be made within 7~~
 21 ~~days after the payments have been received pursuant to the~~
 22 ~~schedule of payments provided in subsection (a) of Section~~
 23 ~~5A-4.~~

24 (7.8) (Blank). ~~For State fiscal year 2008, for making~~
 25 ~~transfers of the moneys received from hospital providers~~
 26 ~~under Section 5A-4 and transferred into the Hospital~~

1 ~~Provider Fund under Section 5A-6 to the designated funds~~
2 ~~not exceeding the following amounts in that State fiscal~~
3 ~~year:~~

4 ~~Health and Human Services~~

5	Medicaid Trust Fund	\$40,000,000
6	Long Term Care Provider Fund	\$60,000,000
7	General Revenue Fund	\$160,000,000.

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

12 (7.9) (Blank). ~~For State fiscal years 2009 through~~
13 ~~2014, for making transfers of the moneys received from~~
14 ~~hospital providers under Section 5A-4 and transferred into~~
15 ~~the Hospital Provider Fund under Section 5A-6 to the~~
16 ~~designated funds not exceeding the following amounts in~~
17 ~~that State fiscal year:~~

18 ~~Health and Human Services~~

19	Medicaid Trust Fund	\$20,000,000
20	Long Term Care Provider Fund	\$30,000,000
21	General Revenue Fund	\$80,000,000.

22 ~~Except as provided under this paragraph, transfers~~
23 ~~under this paragraph shall be made within 7 business days~~
24 ~~after the payments have been received pursuant to the~~
25 ~~schedule of payments provided in subsection (a) of Section~~
26 ~~5A-4. For State fiscal year 2009, transfers to the General~~

1 ~~Revenue Fund under this paragraph shall be made on or~~
2 ~~before June 30, 2009, as sufficient funds become available~~
3 ~~in the Hospital Provider Fund to both make the transfers~~
4 ~~and continue hospital payments.~~

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

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

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

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

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

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

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

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

26 (d) (Blank).

1 (Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3,
2 eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09;
3 96-1530, eff. 2-16-11.)

4 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

5 Sec. 5A-10. Applicability.

6 (a) The assessment imposed by Section 5A-2 shall ~~not take~~
7 ~~effect or shall~~ cease to be imposed and the Department's
8 obligation to make payments shall immediately cease, and any
9 moneys remaining in the Fund shall be refunded to hospital
10 providers in proportion to the amounts paid by them, if:

11 (1) The payments to hospitals required under this
12 Article are not eligible for federal matching funds under
13 Title XIX or XXI of the Social Security Act ~~The sum of the~~
14 ~~appropriations for State fiscal years 2004 and 2005 from~~
15 ~~the General Revenue Fund for hospital payments under the~~
16 ~~medical assistance program is less than \$4,500,000,000 or~~
17 ~~the appropriation for each of State fiscal years 2006, 2007~~
18 ~~and 2008 from the General Revenue Fund for hospital~~
19 ~~payments under the medical assistance program is less than~~
20 ~~\$2,500,000,000 increased annually to reflect any increase~~
21 ~~in the number of recipients, or the annual appropriation~~
22 ~~for State fiscal years 2009, 2010, 2011, 2013, and 2014,~~
23 ~~from the General Revenue Fund combined with the Hospital~~
24 ~~Provider Fund as authorized in Section 5A-8 for hospital~~
25 ~~payments under the medical assistance program, is less than~~

1 ~~the amount appropriated for State fiscal year 2009,~~
2 ~~adjusted annually to reflect any change in the number of~~
3 ~~recipients, excluding State fiscal year 2009 supplemental~~
4 ~~appropriations made necessary by the enactment of the~~
5 ~~American Recovery and Reinvestment Act of 2009; or~~

6 ~~(2) For State fiscal years prior to State fiscal year~~
7 ~~2009, the Department of Healthcare and Family Services~~
8 ~~(formerly Department of Public Aid) makes changes in its~~
9 ~~rules that reduce the hospital inpatient or outpatient~~
10 ~~payment rates, including adjustment payment rates, in~~
11 ~~effect on October 1, 2004, except for hospitals described~~
12 ~~in subsection (b) of Section 5A-3 and except for changes in~~
13 ~~the methodology for calculating outlier payments to~~
14 ~~hospitals for exceptionally costly stays, so long as those~~
15 ~~changes do not reduce aggregate expenditures below the~~
16 ~~amount expended in State fiscal year 2005 for such~~
17 ~~services; or~~

18 (2) ~~(2.1)~~ For State fiscal years 2009 through 2014 and
19 July 1, 2014 through December 31, 2014, the Department of
20 Healthcare and Family Services adopts any administrative
21 rule change to reduce payment rates or alters any payment
22 methodology that reduces any payment rates made to
23 operating hospitals under the approved Title XIX or Title
24 XXI State plan in effect January 1, 2008 except for:

25 (A) any changes for hospitals described in
26 subsection (b) of Section 5A-3; or

1 (B) any rates for payments made under this Article
2 V-A; or

3 (C) any changes proposed in State plan amendment
4 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
5 08-07; ~~or~~

6 (D) in relation to any admissions on or after
7 January 1, 2011, a modification in the methodology for
8 calculating outlier payments to hospitals for
9 exceptionally costly stays, for hospitals reimbursed
10 under the diagnosis-related grouping methodology in
11 effect on January 1, 2011; provided that the Department
12 shall be limited to one such modification during the
13 36-month period after the effective date of this
14 amendatory Act of the 96th General Assembly; or

15 (E) any changes affecting hospitals authorized by
16 this amendatory Act of the 97th General Assembly.

17 ~~(3) The payments to hospitals required under Section~~
18 ~~5A 12 or Section 5A 12.2 are changed or are not eligible~~
19 ~~for federal matching funds under Title XIX or XXI of the~~
20 ~~Social Security Act.~~

21 (b) The assessment imposed by Section 5A-2 shall not take
22 effect or shall cease to be imposed and the Department's
23 obligation to make payments shall immediately cease if the
24 assessment is determined to be an impermissible tax under Title
25 XIX of the Social Security Act. Moneys in the Hospital Provider
26 Fund derived from assessments imposed prior thereto shall be

1 disbursed in accordance with Section 5A-8 to the extent federal
2 financial participation is not reduced due to the
3 impermissibility of the assessments, and any remaining moneys
4 shall be refunded to hospital providers in proportion to the
5 amounts paid by them.

6 (Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72,
7 eff. 7-1-11; 97-74, eff. 6-30-11.)

8 (305 ILCS 5/5A-12.2)

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

10 Sec. 5A-12.2. Hospital access payments on or after July 1,
11 2008.

12 (a) To preserve and improve access to hospital services,
13 for hospital services rendered on or after July 1, 2008, the
14 Illinois Department shall, except for hospitals described in
15 subsection (b) of Section 5A-3, make payments to hospitals as
16 set forth in this Section. These payments shall be paid in 12
17 equal installments on or before the seventh State business day
18 of each month, except that no payment shall be due within 100
19 days after the later of the date of notification of federal
20 approval of the payment methodologies required under this
21 Section or any waiver required under 42 CFR 433.68, at which
22 time the sum of amounts required under this Section prior to
23 the date of notification is due and payable. Payments under
24 this Section are not due and payable, however, until (i) the
25 methodologies described in this Section are approved by the

1 federal government in an appropriate State Plan amendment and
2 (ii) the assessment imposed under this Article is determined to
3 be a permissible tax under Title XIX of the Social Security
4 Act.

5 (a-5) The Illinois Department may, when practicable,
6 accelerate the schedule upon which payments authorized under
7 this Section are made.

8 (b) Across-the-board inpatient adjustment.

9 (1) In addition to rates paid for inpatient hospital
10 services, the Department shall pay to each Illinois general
11 acute care hospital an amount equal to 40% of the total
12 base inpatient payments paid to the hospital for services
13 provided in State fiscal year 2005.

14 (2) In addition to rates paid for inpatient hospital
15 services, the Department shall pay to each freestanding
16 Illinois specialty care hospital as defined in 89 Ill. Adm.
17 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
18 the total base inpatient payments paid to the hospital for
19 services provided in State fiscal year 2005.

20 (3) In addition to rates paid for inpatient hospital
21 services, the Department shall pay to each freestanding
22 Illinois rehabilitation or psychiatric hospital an amount
23 equal to \$1,000 per Medicaid inpatient day multiplied by
24 the increase in the hospital's Medicaid inpatient
25 utilization ratio (determined using the positive
26 percentage change from the rate year 2005 Medicaid

1 inpatient utilization ratio to the rate year 2007 Medicaid
2 inpatient utilization ratio, as calculated by the
3 Department for the disproportionate share determination).

4 (4) In addition to rates paid for inpatient hospital
5 services, the Department shall pay to each Illinois
6 children's hospital an amount equal to 20% of the total
7 base inpatient payments paid to the hospital for services
8 provided in State fiscal year 2005 and an additional amount
9 equal to 20% of the base inpatient payments paid to the
10 hospital for psychiatric services provided in State fiscal
11 year 2005.

12 (5) In addition to rates paid for inpatient hospital
13 services, the Department shall pay to each Illinois
14 hospital eligible for a pediatric inpatient adjustment
15 payment under 89 Ill. Adm. Code 148.298, as in effect for
16 State fiscal year 2007, a supplemental pediatric inpatient
17 adjustment payment equal to:

18 (i) For freestanding children's hospitals as
19 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
20 multiplied by the hospital's pediatric inpatient
21 adjustment payment required under 89 Ill. Adm. Code
22 148.298, as in effect for State fiscal year 2008.

23 (ii) For hospitals other than freestanding
24 children's hospitals as defined in 89 Ill. Adm. Code
25 149.50(c)(3)(B), 1.0 multiplied by the hospital's
26 pediatric inpatient adjustment payment required under

1 89 Ill. Adm. Code 148.298, as in effect for State
2 fiscal year 2008.

3 (c) Outpatient adjustment.

4 (1) In addition to the rates paid for outpatient
5 hospital services, the Department shall pay each Illinois
6 hospital an amount equal to 2.2 multiplied by the
7 hospital's ambulatory procedure listing payments for
8 categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code
9 148.140(b), for State fiscal year 2005.

10 (2) In addition to the rates paid for outpatient
11 hospital services, the Department shall pay each Illinois
12 freestanding psychiatric hospital an amount equal to 3.25
13 multiplied by the hospital's ambulatory procedure listing
14 payments for category 5b, as defined in 89 Ill. Adm. Code
15 148.140(b)(1)(E), for State fiscal year 2005.

16 (d) Medicaid high volume adjustment. In addition to rates
17 paid for inpatient hospital services, the Department shall pay
18 to each Illinois general acute care hospital that provided more
19 than 20,500 Medicaid inpatient days of care in State fiscal
20 year 2005 amounts as follows:

21 (1) For hospitals with a case mix index equal to or
22 greater than the 85th percentile of hospital case mix
23 indices, \$350 for each Medicaid inpatient day of care
24 provided during that period; and

25 (2) For hospitals with a case mix index less than the
26 85th percentile of hospital case mix indices, \$100 for each

1 Medicaid inpatient day of care provided during that period.

2 (e) Capital adjustment. In addition to rates paid for
3 inpatient hospital services, the Department shall pay an
4 additional payment to each Illinois general acute care hospital
5 that has a Medicaid inpatient utilization rate of at least 10%
6 (as calculated by the Department for the rate year 2007
7 disproportionate share determination) amounts as follows:

8 (1) For each Illinois general acute care hospital that
9 has a Medicaid inpatient utilization rate of at least 10%
10 and less than 36.94% and whose capital cost is less than
11 the 60th percentile of the capital costs of all Illinois
12 hospitals, the amount of such payment shall equal the
13 hospital's Medicaid inpatient days multiplied by the
14 difference between the capital costs at the 60th percentile
15 of the capital costs of all Illinois hospitals and the
16 hospital's capital costs.

17 (2) For each Illinois general acute care hospital that
18 has a Medicaid inpatient utilization rate of at least
19 36.94% and whose capital cost is less than the 75th
20 percentile of the capital costs of all Illinois hospitals,
21 the amount of such payment shall equal the hospital's
22 Medicaid inpatient days multiplied by the difference
23 between the capital costs at the 75th percentile of the
24 capital costs of all Illinois hospitals and the hospital's
25 capital costs.

26 (f) Obstetrical care adjustment.

1 (1) In addition to rates paid for inpatient hospital
2 services, the Department shall pay \$1,500 for each Medicaid
3 obstetrical day of care provided in State fiscal year 2005
4 by each Illinois rural hospital that had a Medicaid
5 obstetrical percentage (Medicaid obstetrical days divided
6 by Medicaid inpatient days) greater than 15% for State
7 fiscal year 2005.

8 (2) In addition to rates paid for inpatient hospital
9 services, the Department shall pay \$1,350 for each Medicaid
10 obstetrical day of care provided in State fiscal year 2005
11 by each Illinois general acute care hospital that was
12 designated a level III perinatal center as of December 31,
13 2006, and that had a case mix index equal to or greater
14 than the 45th percentile of the case mix indices for all
15 level III perinatal centers.

16 (3) In addition to rates paid for inpatient hospital
17 services, the Department shall pay \$900 for each Medicaid
18 obstetrical day of care provided in State fiscal year 2005
19 by each Illinois general acute care hospital that was
20 designated a level II or II+ perinatal center as of
21 December 31, 2006, and that had a case mix index equal to
22 or greater than the 35th percentile of the case mix indices
23 for all level II and II+ perinatal centers.

24 (g) Trauma adjustment.

25 (1) In addition to rates paid for inpatient hospital
26 services, the Department shall pay each Illinois general

1 acute care hospital designated as a trauma center as of
2 July 1, 2007, a payment equal to 3.75 multiplied by the
3 hospital's State fiscal year 2005 Medicaid capital
4 payments.

5 (2) In addition to rates paid for inpatient hospital
6 services, the Department shall pay \$400 for each Medicaid
7 acute inpatient day of care provided in State fiscal year
8 2005 by each Illinois general acute care hospital that was
9 designated a level II trauma center, as defined in 89 Ill.
10 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,
11 2007.

12 (3) In addition to rates paid for inpatient hospital
13 services, the Department shall pay \$235 for each Illinois
14 Medicaid acute inpatient day of care provided in State
15 fiscal year 2005 by each level I pediatric trauma center
16 located outside of Illinois that had more than 8,000
17 Illinois Medicaid inpatient days in State fiscal year 2005.

18 (h) Supplemental tertiary care adjustment. In addition to
19 rates paid for inpatient services, the Department shall pay to
20 each Illinois hospital eligible for tertiary care adjustment
21 payments under 89 Ill. Adm. Code 148.296, as in effect for
22 State fiscal year 2007, a supplemental tertiary care adjustment
23 payment equal to the tertiary care adjustment payment required
24 under 89 Ill. Adm. Code 148.296, as in effect for State fiscal
25 year 2007.

26 (i) Crossover adjustment. In addition to rates paid for

1 inpatient services, the Department shall pay each Illinois
2 general acute care hospital that had a ratio of crossover days
3 to total inpatient days for medical assistance programs
4 administered by the Department (utilizing information from
5 2005 paid claims) greater than 50%, and a case mix index
6 greater than the 65th percentile of case mix indices for all
7 Illinois hospitals, a rate of \$1,125 for each Medicaid
8 inpatient day including crossover days.

9 (j) Magnet hospital adjustment. In addition to rates paid
10 for inpatient hospital services, the Department shall pay to
11 each Illinois general acute care hospital and each Illinois
12 freestanding children's hospital that, as of February 1, 2008,
13 was recognized as a Magnet hospital by the American Nurses
14 Credentialing Center and that had a case mix index greater than
15 the 75th percentile of case mix indices for all Illinois
16 hospitals amounts as follows:

17 (1) For hospitals located in a county whose eligibility
18 growth factor is greater than the mean, \$450 multiplied by
19 the eligibility growth factor for the county in which the
20 hospital is located for each Medicaid inpatient day of care
21 provided by the hospital during State fiscal year 2005.

22 (2) For hospitals located in a county whose eligibility
23 growth factor is less than or equal to the mean, \$225
24 multiplied by the eligibility growth factor for the county
25 in which the hospital is located for each Medicaid
26 inpatient day of care provided by the hospital during State

1 fiscal year 2005.

2 For purposes of this subsection, "eligibility growth
3 factor" means the percentage by which the number of Medicaid
4 recipients in the county increased from State fiscal year 1998
5 to State fiscal year 2005.

6 (k) For purposes of this Section, a hospital that is
7 enrolled to provide Medicaid services during State fiscal year
8 2005 shall have its utilization and associated reimbursements
9 annualized prior to the payment calculations being performed
10 under this Section.

11 (l) For purposes of this Section, the terms "Medicaid
12 days", "ambulatory procedure listing services", and
13 "ambulatory procedure listing payments" do not include any
14 days, charges, or services for which Medicare or a managed care
15 organization reimbursed on a capitated basis was liable for
16 payment, except where explicitly stated otherwise in this
17 Section.

18 (m) For purposes of this Section, in determining the
19 percentile ranking of an Illinois hospital's case mix index or
20 capital costs, hospitals described in subsection (b) of Section
21 5A-3 shall be excluded from the ranking.

22 (n) Definitions. Unless the context requires otherwise or
23 unless provided otherwise in this Section, the terms used in
24 this Section for qualifying criteria and payment calculations
25 shall have the same meanings as those terms have been given in
26 the Illinois Department's administrative rules as in effect on

1 March 1, 2008. Other terms shall be defined by the Illinois
2 Department by rule.

3 As used in this Section, unless the context requires
4 otherwise:

5 "Base inpatient payments" means, for a given hospital, the
6 sum of base payments for inpatient services made on a per diem
7 or per admission (DRG) basis, excluding those portions of per
8 admission payments that are classified as capital payments.
9 Disproportionate share hospital adjustment payments, Medicaid
10 Percentage Adjustments, Medicaid High Volume Adjustments, and
11 outlier payments, as defined by rule by the Department as of
12 January 1, 2008, are not base payments.

13 "Capital costs" means, for a given hospital, the total
14 capital costs determined using the most recent 2005 Medicare
15 cost report as contained in the Healthcare Cost Report
16 Information System file, for the quarter ending on December 31,
17 2006, divided by the total inpatient days from the same cost
18 report to calculate a capital cost per day. The resulting
19 capital cost per day is inflated to the midpoint of State
20 fiscal year 2009 utilizing the national hospital market price
21 proxies (DRI) hospital cost index. If a hospital's 2005
22 Medicare cost report is not contained in the Healthcare Cost
23 Report Information System, the Department may obtain the data
24 necessary to compute the hospital's capital costs from any
25 source available, including, but not limited to, records
26 maintained by the hospital provider, which may be inspected at

1 all times during business hours of the day by the Illinois
2 Department or its duly authorized agents and employees.

3 "Case mix index" means, for a given hospital, the sum of
4 the DRG relative weighting factors in effect on January 1,
5 2005, for all general acute care admissions for State fiscal
6 year 2005, excluding Medicare crossover admissions and
7 transplant admissions reimbursed under 89 Ill. Adm. Code
8 148.82, divided by the total number of general acute care
9 admissions for State fiscal year 2005, excluding Medicare
10 crossover admissions and transplant admissions reimbursed
11 under 89 Ill. Adm. Code 148.82.

12 "Medicaid inpatient day" means, for a given hospital, the
13 sum of days of inpatient hospital days provided to recipients
14 of medical assistance under Title XIX of the federal Social
15 Security Act, excluding days for individuals eligible for
16 Medicare under Title XVIII of that Act (Medicaid/Medicare
17 crossover days), as tabulated from the Department's paid claims
18 data for admissions occurring during State fiscal year 2005
19 that was adjudicated by the Department through March 23, 2007.

20 "Medicaid obstetrical day" means, for a given hospital, the
21 sum of days of inpatient hospital days grouped by the
22 Department to DRGs of 370 through 375 provided to recipients of
23 medical assistance under Title XIX of the federal Social
24 Security Act, excluding days for individuals eligible for
25 Medicare under Title XVIII of that Act (Medicaid/Medicare
26 crossover days), as tabulated from the Department's paid claims

1 data for admissions occurring during State fiscal year 2005
2 that was adjudicated by the Department through March 23, 2007.

3 "Outpatient ambulatory procedure listing payments" means,
4 for a given hospital, the sum of payments for ambulatory
5 procedure listing services, as described in 89 Ill. Adm. Code
6 148.140(b), provided to recipients of medical assistance under
7 Title XIX of the federal Social Security Act, excluding
8 payments for individuals eligible for Medicare under Title
9 XVIII of the Act (Medicaid/Medicare crossover days), as
10 tabulated from the Department's paid claims data for services
11 occurring in State fiscal year 2005 that were adjudicated by
12 the Department through March 23, 2007.

13 (o) The Department may adjust payments made under this
14 Section 5A-12.2 ~~12.2~~ to comply with federal law or regulations
15 regarding hospital-specific payment limitations on
16 government-owned or government-operated hospitals.

17 (p) Notwithstanding any of the other provisions of this
18 Section, the Department is authorized to adopt rules that
19 change the hospital access improvement payments specified in
20 this Section, but only to the extent necessary to conform to
21 any federally approved amendment to the Title XIX State plan.
22 Any such rules shall be adopted by the Department as authorized
23 by Section 5-50 of the Illinois Administrative Procedure Act.
24 Notwithstanding any other provision of law, any changes
25 implemented as a result of this subsection (p) shall be given
26 retroactive effect so that they shall be deemed to have taken

1 effect as of the effective date of this Section.

2 (q) (Blank). ~~For State fiscal years 2012 and 2013, the~~
3 ~~Department may make recommendations to the General Assembly~~
4 ~~regarding the use of more recent data for purposes of~~
5 ~~calculating the assessment authorized under Section 5A-2 and~~
6 ~~the payments authorized under this Section 5A-12.2.~~

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

12 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09.)

13 (305 ILCS 5/5A-14)

14 Sec. 5A-14. Repeal of assessments and disbursements.

15 (a) Section 5A-2 is repealed on January 1, 2015 ~~July 1,~~
16 ~~2014.~~

17 (b) Section 5A-12 is repealed on July 1, 2005.

18 (c) Section 5A-12.1 is repealed on July 1, 2008.

19 (d) Section 5A-12.2 is repealed on January 1, 2015 ~~July 1,~~
20 ~~2014.~~

21 (e) Section 5A-12.3 is repealed on July 1, 2011.

22 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09;
23 96-1530, eff. 2-16-11.)

24 (305 ILCS 5/5A-15 new)

1 Sec. 5A-15. Protection of federal revenue.

2 (a) If the federal Centers for Medicare and Medicaid
3 Services finds that any federal upper payment limit applicable
4 to the payments under this Article is exceeded then:

5 (1) the payments under this Article that exceed the
6 applicable federal upper payment limit shall be reduced
7 uniformly to the extent necessary to comply with the
8 applicable federal upper payment limit; and

9 (2) any assessment rate imposed under this Article
10 shall be reduced such that the aggregate assessment is
11 reduced by the same percentage reduction applied in
12 paragraph (1); and

13 (3) any transfers from the Hospital Provider Fund under
14 Section 5A-8 shall be reduced by the same percentage
15 reduction applied in paragraph (1).

16 (b) Any payment reductions made under the authority granted
17 in this Section are exempt from the requirements and actions
18 under Section 5A-10.

19 (305 ILCS 5/6-11) (from Ch. 23, par. 6-11)

20 Sec. 6-11. ~~State funded~~ General Assistance.

21 (a) Effective July 1, 1992, all State funded General
22 Assistance and related medical benefits shall be governed by
23 this Section, provided that, notwithstanding any other
24 provisions of this Code to the contrary, on and after July 1,
25 2012, the State shall not fund the programs outlined in this

1 Section. Other parts of this Code or other laws related to
2 General Assistance shall remain in effect to the extent they do
3 not conflict with the provisions of this Section. If any other
4 part of this Code or other laws of this State conflict with the
5 provisions of this Section, the provisions of this Section
6 shall control.

7 (b) ~~State funded~~ General Assistance may ~~shall~~ consist of 2
8 separate programs. One program shall be for adults with no
9 children and shall be known as ~~State~~ Transitional Assistance.
10 The other program may ~~shall~~ be for families with children and
11 for pregnant women and shall be known as ~~State~~ Family and
12 Children Assistance.

13 (c) (1) To be eligible for ~~State~~ Transitional Assistance on
14 or after July 1, 1992, an individual must be ineligible for
15 assistance under any other Article of this Code, must be
16 determined chronically needy, and must be one of the following:

17 (A) age 18 or over or

18 (B) married and living with a spouse, regardless of
19 age.

20 (2) The ~~Illinois Department or the~~ local governmental unit
21 shall determine whether individuals are chronically needy as
22 follows:

23 (A) Individuals who have applied for Supplemental
24 Security Income (SSI) and are awaiting a decision on
25 eligibility for SSI who are determined disabled by the
26 Illinois Department using the SSI standard shall be

1 considered chronically needy, except that individuals
2 whose disability is based solely on substance addictions
3 (drug abuse and alcoholism) and whose disability would
4 cease were their addictions to end shall be eligible only
5 for medical assistance and shall not be eligible for cash
6 assistance under the ~~State~~ Transitional Assistance
7 program.

8 (B) (Blank). ~~If an individual has been denied SSI due~~
9 ~~to a finding of "not disabled" (either at the~~
10 ~~Administrative Law Judge level or above, or at a lower~~
11 ~~level if that determination was not appealed), the Illinois~~
12 ~~Department shall adopt that finding and the individual~~
13 ~~shall not be eligible for State Transitional Assistance or~~
14 ~~any related medical benefits. Such an individual may not be~~
15 ~~determined disabled by the Illinois Department for a period~~
16 ~~of 12 months, unless the individual shows that there has~~
17 ~~been a substantial change in his or her medical condition~~
18 ~~or that there has been a substantial change in other~~
19 ~~factors, such as age or work experience, that might change~~
20 ~~the determination of disability.~~

21 (C) The unit of local government ~~Illinois Department,~~
22 ~~by rule,~~ may specify other categories of individuals as
23 chronically needy; nothing in this Section, however, shall
24 be deemed to require the inclusion of any specific category
25 other than as specified in paragraph ~~paragraphs~~ (A) ~~and~~
26 ~~(B)~~.

1 (3) For individuals in ~~State~~ Transitional Assistance,
2 medical assistance ~~may shall~~ be provided by the unit of local
3 government in an amount and nature determined by the unit of
4 local government. ~~Nothing Department of Healthcare and Family~~
5 ~~Services by rule. The amount and nature of medical assistance~~
6 ~~provided need not be the same as that provided under paragraph~~
7 ~~(4) of subsection (d) of this Section, and nothing in this~~
8 paragraph (3) shall be construed to require the coverage of any
9 particular medical service. In addition, the amount and nature
10 of medical assistance provided may be different for different
11 categories of individuals determined chronically needy.

12 (4) (Blank). ~~The Illinois Department shall determine, by~~
13 ~~rule, those assistance recipients under Article VI who shall be~~
14 ~~subject to employment, training, or education programs~~
15 ~~including Earnfare, the content of those programs, and the~~
16 ~~penalties for failure to cooperate in those programs.~~

17 (5) (Blank). ~~The Illinois Department shall, by rule,~~
18 ~~establish further eligibility requirements, including but not~~
19 ~~limited to residence, need, and the level of payments.~~

20 (d) (1) To be eligible for ~~State~~ Family and Children
21 Assistance, a family unit must be ineligible for assistance
22 under any other Article of this Code and must contain a child
23 who is:

24 (A) under age 18 or

25 (B) age 18 and a full-time student in a secondary
26 school or the equivalent level of vocational or technical

1 training, and who may reasonably be expected to complete
2 the program before reaching age 19.

3 Those children shall be eligible for ~~State~~ Family and
4 Children Assistance.

5 (2) The natural or adoptive parents of the child living in
6 the same household may be eligible for ~~State~~ Family and
7 Children Assistance.

8 (3) A pregnant woman whose pregnancy has been verified
9 shall be eligible for income maintenance assistance under the
10 ~~State~~ Family and Children Assistance program.

11 (4) The amount and nature of medical assistance provided
12 under the ~~State~~ Family and Children Assistance program shall be
13 determined by the unit of local government ~~Department of~~
14 ~~Healthcare and Family Services by rule~~. The amount and nature
15 of medical assistance provided need not be the same as that
16 provided under paragraph (3) of subsection (c) of this Section,
17 and nothing in this paragraph (4) shall be construed to require
18 the coverage of any particular medical service.

19 (5) (Blank). ~~The Illinois Department shall, by rule,~~
20 ~~establish further eligibility requirements, including but not~~
21 ~~limited to residence, need, and the level of payments.~~

22 (e) A local governmental unit that chooses to participate
23 in a General Assistance program under this Section shall
24 provide funding in accordance with Section 12-21.13 of this
25 Act. Local governmental funds used to qualify for State funding
26 may only be expended for clients eligible for assistance under

1 this Section 6-11 and related administrative expenses.

2 (f) (Blank). ~~In order to qualify for State funding under~~
3 ~~this Section, a local governmental unit shall be subject to the~~
4 ~~supervision and the rules and regulations of the Illinois~~
5 ~~Department.~~

6 (g) (Blank). ~~Notwithstanding any other provision in this~~
7 ~~Code, the Illinois Department is authorized to reduce payment~~
8 ~~levels used to determine cash grants provided to recipients of~~
9 ~~State Transitional Assistance at any time within a Fiscal Year~~
10 ~~in order to ensure that cash benefits for State Transitional~~
11 ~~Assistance do not exceed the amounts appropriated for those~~
12 ~~cash benefits. Changes in payment levels may be accomplished by~~
13 ~~emergency rule under Section 5-45 of the Illinois~~
14 ~~Administrative Procedure Act, except that the limitation on the~~
15 ~~number of emergency rules that may be adopted in a 24 month~~
16 ~~period shall not apply and the provisions of Sections 5-115 and~~
17 ~~5-125 of the Illinois Administrative Procedure Act shall not~~
18 ~~apply. This provision shall also be applicable to any reduction~~
19 ~~in payment levels made upon implementation of this amendatory~~
20 ~~Act of 1995.~~

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

22 (305 ILCS 5/11-5.2 new)

23 Sec. 11-5.2. Income, Residency, and Identity Verification
24 System.

25 (a) The Department shall ensure that its proposed

1 integrated eligibility system shall include the computerized
2 functions of income, residency, and identity eligibility
3 verification to verify eligibility, eliminate duplication of
4 medical assistance, and deter fraud. Until the integrated
5 eligibility system is operational, the Department may enter
6 into a contract with the vendor selected pursuant to Section
7 11-5.3 as necessary to obtain the electronic data matching
8 described in this Section. This contract shall be exempt from
9 the Illinois Procurement Code pursuant to subsection (h) of
10 Section 1-10 of that Code.

11 (b) Prior to awarding medical assistance at application
12 under Article V of this Code, the Department shall, to the
13 extent such databases are available to the Department, conduct
14 data matches using the name, date of birth, address, and Social
15 Security Number of each applicant or recipient or responsible
16 relative of an applicant or recipient against the following:

17 (1) Income tax information.

18 (2) Employer reports of income and unemployment
19 insurance payment information maintained by the Department
20 of Employment Security.

21 (3) Earned and unearned income, citizenship and death,
22 and other relevant information maintained by the Social
23 Security Administration.

24 (4) Immigration status information maintained by the
25 United States Citizenship and Immigration Services.

26 (5) Wage reporting and similar information maintained

1 by states contiguous to this State.

2 (6) Employment information maintained by the
3 Department of Employment Security in its New Hire Directory
4 database.

5 (7) Employment information maintained by the United
6 States Department of Health and Human Services in its
7 National Directory of New Hires database.

8 (8) Veterans' benefits information maintained by the
9 United States Department of Health and Human Services, in
10 coordination with the Department of Health and Human
11 Services and the Department of Veterans' Affairs, in the
12 federal Public Assistance Reporting Information System
13 (PARIS) database.

14 (9) Residency information maintained by the Illinois
15 Secretary of State.

16 (10) A database which is substantially similar to or a
17 successor of a database described in this Section that
18 contains information relevant for verifying eligibility
19 for medical assistance.

20 (d) If a discrepancy results between information provided
21 by an applicant, recipient, or responsible relative and
22 information contained in one or more of the databases or
23 information tools listed under subsection (b) or (c) of this
24 Section or subsection (c) of Section 11-5.3 and that
25 discrepancy calls into question the accuracy of information
26 relevant to a condition of eligibility provided by the

1 applicant, recipient, or responsible relative, the Department
2 or its contractor shall review the applicant's or recipient's
3 case using the following procedures:

4 (1) If the information discovered under subsection (c)
5 of this Section or subsection (c) of Section 11-5.3 does
6 not result in the Department finding the applicant or
7 recipient ineligible for assistance under Article V of this
8 Code, the Department shall finalize the determination or
9 redetermination of eligibility.

10 (2) If the information discovered results in the
11 Department finding the applicant or recipient ineligible
12 for assistance, the Department shall provide notice as set
13 forth in Section 11-7 of this Article.

14 (3) If the information discovered is insufficient to
15 determine that the applicant or recipient is eligible or
16 ineligible, the Department shall provide written notice to
17 the applicant or recipient which shall describe in
18 sufficient detail the circumstances of the discrepancy,
19 the information or documentation required, the manner in
20 which the applicant or recipient may respond, and the
21 consequences of failing to take action. The applicant or
22 recipient shall have 10 business days to respond.

23 (4) If the applicant or recipient does not respond to
24 the notice, the Department shall deny assistance for
25 failure to cooperate, in which case the Department shall
26 provide notice as set forth in Section 11-7. Eligibility

1 for assistance shall not be established until the
2 discrepancy has been resolved.

3 (5) If an applicant or recipient responds to the
4 notice, the Department shall determine the effect of the
5 information or documentation provided on the applicant's
6 or recipient's case and shall take appropriate action.
7 Written notice of the Department's action shall be provided
8 as set forth in Section 11-7 of this Article.

9 (6) Suspected cases of fraud shall be referred to the
10 Department's Inspector General.

11 (e) The Department shall adopt any rules necessary to
12 implement this Section.

13 (305 ILCS 5/11-5.3 new)

14 Sec. 11-5.3. Procurement of vendor to verify eligibility
15 for assistance under Article V.

16 (a) No later than 60 days after the effective date of this
17 amendatory Act of the 97th General Assembly, the Chief
18 Procurement Officer for General Services, in consultation with
19 the Department of Healthcare and Family Services, shall conduct
20 and complete any procurement necessary to procure a vendor to
21 verify eligibility for assistance under Article V of this Code.
22 Such authority shall include procuring a vendor to assist the
23 Chief Procurement Officer in conducting the procurement. The
24 Chief Procurement Officer and the Department shall jointly
25 negotiate final contract terms with a vendor selected by the

1 Chief Procurement Officer. Within 30 days of selection of an
2 eligibility verification vendor, the Department of Healthcare
3 and Family Services shall enter into a contract with the
4 selected vendor. The Department of Healthcare and Family
5 Services and the Department of Human Services shall cooperate
6 with and provide any information requested by the Chief
7 Procurement Officer to conduct the procurement.

8 (b) Notwithstanding any other provision of law, any
9 procurement or contract necessary to comply with this Section
10 shall be exempt from: (i) the Illinois Procurement Code
11 pursuant to Section 1-10(h) of the Illinois Procurement Code,
12 except that bidders shall comply with the disclosure
13 requirement in Sections 50-10.5(a) through (d), 50-13, 50-35,
14 and 50-37 of the Illinois Procurement Code and a vendor awarded
15 a contract under this Section shall comply with Section 50-37
16 of the Procurement Code; (ii) any administrative rules of this
17 State pertaining to procurement or contract formation; and
18 (iii) any State or Department policies or procedures pertaining
19 to procurement, contract formation, contract award, and
20 Business Enterprise Program approval.

21 (c) Upon becoming operational, the contractor shall
22 conduct data matches using the name, date of birth, address,
23 and Social Security Number of each applicant and recipient
24 against public records to verify eligibility. The contractor,
25 upon preliminary determination that an enrollee is eligible or
26 ineligible, shall notify the Department. Within 20 business

1 days of such notification, the Department shall accept the
2 recommendation or reject it with a stated reason. The
3 Department shall retain final authority over eligibility
4 determinations. The contractor shall keep a record of all
5 preliminary determinations of ineligibility communicated to
6 the Department. Within 30 days of the end of each calendar
7 quarter, the Department and contractor shall file a joint
8 report on a quarterly basis to the Governor, the Speaker of the
9 House of Representatives, the Minority Leader of the House of
10 Representatives, the Senate President, and the Senate Minority
11 Leader. The report shall include, but shall not be limited to,
12 monthly recommendations of preliminary determinations of
13 eligibility or ineligibility communicated by the contractor,
14 the actions taken on those preliminary determinations by the
15 Department, and the stated reasons for those recommendations
16 that the Department rejected.

17 (d) An eligibility verification vendor contract shall be
18 awarded for an initial 2-year period with up to a maximum of 2
19 one-year renewal options. Nothing in this Section shall compel
20 the award of a contract to a vendor that fails to meet the
21 needs of the Department. A contract with a vendor to assist in
22 the procurement shall be awarded for a period of time not to
23 exceed 6 months.

24 (305 ILCS 5/11-13) (from Ch. 23, par. 11-13)

25 Sec. 11-13. Conditions For Receipt of Vendor Payments -

1 Limitation Period For Vendor Action - Penalty For Violation. A
2 vendor payment, as defined in Section 2-5 of Article II, shall
3 constitute payment in full for the goods or services covered
4 thereby. Acceptance of the payment by or in behalf of the
5 vendor shall bar him from obtaining, or attempting to obtain,
6 additional payment therefor from the recipient or any other
7 person. A vendor payment shall not, however, bar recovery of
8 the value of goods and services the obligation for which, under
9 the rules and regulations of the Illinois Department, is to be
10 met from the income and resources available to the recipient,
11 and in respect to which the vendor payment of the Illinois
12 Department or the local governmental unit represents
13 supplementation of such available income and resources.

14 Vendors seeking to enforce obligations of a governmental
15 unit or the Illinois Department for goods or services (1)
16 furnished to or in behalf of recipients and (2) subject to a
17 vendor payment as defined in Section 2-5, shall commence their
18 actions in the appropriate Circuit Court or the Court of
19 Claims, as the case may require, within one year next after the
20 cause of action accrued.

21 A cause of action accrues within the meaning of this
22 Section upon the following date:

23 (1) If the vendor can prove that he submitted a bill for
24 the service rendered to the Illinois Department or a
25 governmental unit within 180 days after ~~12 months~~ of the date
26 the service was rendered, then (a) upon the date the Illinois

1 Department or a governmental unit mails to the vendor
2 information that it is paying a bill in part or is refusing to
3 pay a bill in whole or in part, or (b) upon the date one year
4 following the date the vendor submitted such bill if the
5 Illinois Department or a governmental unit fails to mail to the
6 vendor such payment information within one year following the
7 date the vendor submitted the bill; or

8 (2) If the vendor cannot prove that he submitted a bill for
9 the service rendered within 180 days after ~~12 months of~~ the
10 date the service was rendered, then upon the date 12 months
11 following the date the vendor rendered the service to the
12 recipient.

13 In the case of long term care facilities, where the
14 Illinois Department initiates the monthly billing process for
15 the vendor, the cause of action shall accrue 12 months after
16 the last day of the month the service was rendered.

17 This paragraph governs only vendor payments as defined in
18 this Code and as limited by regulations of the Illinois
19 Department; it does not apply to goods or services purchased or
20 contracted for by a recipient under circumstances in which the
21 payment is to be made directly by the recipient.

22 Any vendor who accepts a vendor payment and who knowingly
23 obtains or attempts to obtain additional payment for the goods
24 or services covered by the vendor payment from the recipient or
25 any other person shall be guilty of a Class B misdemeanor.

26 (Source: P.A. 86-430.)

1 (305 ILCS 5/11-26) (from Ch. 23, par. 11-26)

2 Sec. 11-26. Recipient's abuse of medical care;
3 restrictions on access to medical care.

4 (a) When the Department determines, on the basis of
5 statistical norms and medical judgment, that a medical care
6 recipient has received medical services in excess of need and
7 with such frequency or in such a manner as to constitute an
8 abuse of the recipient's medical care privileges, the
9 recipient's access to medical care may be restricted.

10 (b) When the Department has determined that a recipient is
11 abusing his or her medical care privileges as described in this
12 Section, it may require that the recipient designate a primary
13 provider type of the recipient's own choosing to assume
14 responsibility for the recipient's care. For the purposes of
15 this subsection, "primary provider type" means a provider type
16 as determined by the Department ~~primary care provider, primary~~
17 ~~care pharmacy, primary dentist, primary podiatrist, or primary~~
18 ~~durable medical equipment provider~~. Instead of requiring a
19 recipient to make a designation as provided in this subsection,
20 the Department, pursuant to rules adopted by the Department and
21 without regard to any choice of an entity that the recipient
22 might otherwise make, may initially designate a primary
23 provider type provided that the primary provider type is
24 willing to provide that care.

25 (c) When the Department has requested that a recipient

1 designate a primary provider type and the recipient fails or
2 refuses to do so, the Department may, after a reasonable period
3 of time, assign the recipient to a primary provider type of its
4 own choice and determination, provided such primary provider
5 type is willing to provide such care.

6 (d) When a recipient has been restricted to a designated
7 primary provider type, the recipient may change the primary
8 provider type:

9 (1) when the designated source becomes unavailable, as
10 the Department shall determine by rule; or

11 (2) when the designated primary provider type notifies
12 the Department that it wishes to withdraw from any
13 obligation as primary provider type; or

14 (3) in other situations, as the Department shall
15 provide by rule.

16 The Department shall, by rule, establish procedures for
17 providing medical or pharmaceutical services when the
18 designated source becomes unavailable or wishes to withdraw
19 from any obligation as primary provider type, shall, by rule,
20 take into consideration the need for emergency or temporary
21 medical assistance and shall ensure that the recipient has
22 continuous and unrestricted access to medical care from the
23 date on which such unavailability or withdrawal becomes
24 effective until such time as the recipient designates a primary
25 provider type or a primary provider type willing to provide
26 such care is designated by the Department consistent with

1 subsections (b) and (c) and such restriction becomes effective.

2 (e) Prior to initiating any action to restrict a
3 recipient's access to medical or pharmaceutical care, the
4 Department shall notify the recipient of its intended action.
5 Such notification shall be in writing and shall set forth the
6 reasons for and nature of the proposed action. In addition, the
7 notification shall:

8 (1) inform the recipient that (i) the recipient has a
9 right to designate a primary provider type of the
10 recipient's own choosing willing to accept such
11 designation and that the recipient's failure to do so
12 within a reasonable time may result in such designation
13 being made by the Department or (ii) the Department has
14 designated a primary provider type to assume
15 responsibility for the recipient's care; and

16 (2) inform the recipient that the recipient has a right
17 to appeal the Department's determination to restrict the
18 recipient's access to medical care and provide the
19 recipient with an explanation of how such appeal is to be
20 made. The notification shall also inform the recipient of
21 the circumstances under which unrestricted medical
22 eligibility shall continue until a decision is made on
23 appeal and that if the recipient chooses to appeal, the
24 recipient will be able to review the medical payment data
25 that was utilized by the Department to decide that the
26 recipient's access to medical care should be restricted.

1 (f) The Department shall, by rule or regulation, establish
2 procedures for appealing a determination to restrict a
3 recipient's access to medical care, which procedures shall, at
4 a minimum, provide for a reasonable opportunity to be heard
5 and, where the appeal is denied, for a written statement of the
6 reason or reasons for such denial.

7 (g) Except as otherwise provided in this subsection, when a
8 recipient has had his or her medical card restricted for 4 full
9 quarters (without regard to any period of ineligibility for
10 medical assistance under this Code, or any period for which the
11 recipient voluntarily terminates his or her receipt of medical
12 assistance, that may occur before the expiration of those 4
13 full quarters), the Department shall reevaluate the
14 recipient's medical usage to determine whether it is still in
15 excess of need and with such frequency or in such a manner as
16 to constitute an abuse of the receipt of medical assistance. If
17 it is still in excess of need, the restriction shall be
18 continued for another 4 full quarters. If it is no longer in
19 excess of need, the restriction shall be discontinued. If a
20 recipient's access to medical care has been restricted under
21 this Section and the Department then determines, either at
22 reevaluation or after the restriction has been discontinued, to
23 restrict the recipient's access to medical care a second or
24 subsequent time, the second or subsequent restriction may be
25 imposed for a period of more than 4 full quarters. If the
26 Department restricts a recipient's access to medical care for a

1 period of more than 4 full quarters, as determined by rule, the
2 Department shall reevaluate the recipient's medical usage
3 after the end of the restriction period rather than after the
4 end of 4 full quarters. The Department shall notify the
5 recipient, in writing, of any decision to continue the
6 restriction and the reason or reasons therefor. A "quarter",
7 for purposes of this Section, shall be defined as one of the
8 following 3-month periods of time: January-March, April-June,
9 July-September or October-December.

10 (h) In addition to any other recipient whose acquisition of
11 medical care is determined to be in excess of need, the
12 Department may restrict the medical care privileges of the
13 following persons:

14 (1) recipients found to have loaned or altered their
15 cards or misused or falsely represented medical coverage;

16 (2) recipients found in possession of blank or forged
17 prescription pads;

18 (3) recipients who knowingly assist providers in
19 rendering excessive services or defrauding the medical
20 assistance program.

21 The procedural safeguards in this Section shall apply to
22 the above individuals.

23 (i) Restrictions under this Section shall be in addition to
24 and shall not in any way be limited by or limit any actions
25 taken under Article VIII-A of this Code.

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

1 (305 ILCS 5/12-4.25) (from Ch. 23, par. 12-4.25)

2 Sec. 12-4.25. Medical assistance program; vendor
3 participation.

4 (A) The Illinois Department may deny, suspend, or terminate
5 the eligibility of any person, firm, corporation, association,
6 agency, institution or other legal entity to participate as a
7 vendor of goods or services to recipients under the medical
8 assistance program under Article V, or may exclude any such
9 person or entity from participation as such a vendor, and may
10 deny, suspend, or recover payments, if after reasonable notice
11 and opportunity for a hearing the Illinois Department finds:

12 (a) Such vendor is not complying with the Department's
13 policy or rules and regulations, or with the terms and
14 conditions prescribed by the Illinois Department in its
15 vendor agreement, which document shall be developed by the
16 Department as a result of negotiations with each vendor
17 category, including physicians, hospitals, long term care
18 facilities, pharmacists, optometrists, podiatrists and
19 dentists setting forth the terms and conditions applicable
20 to the participation of each vendor group in the program;
21 or

22 (b) Such vendor has failed to keep or make available
23 for inspection, audit or copying, after receiving a written
24 request from the Illinois Department, such records
25 regarding payments claimed for providing services. This

1 section does not require vendors to make available patient
2 records of patients for whom services are not reimbursed
3 under this Code; or

4 (c) Such vendor has failed to furnish any information
5 requested by the Department regarding payments for
6 providing goods or services; or

7 (d) Such vendor has knowingly made, or caused to be
8 made, any false statement or representation of a material
9 fact in connection with the administration of the medical
10 assistance program; or

11 (e) Such vendor has furnished goods or services to a
12 recipient which are (1) in excess of need ~~his or her needs~~,
13 (2) harmful ~~to the recipient~~, or (3) of grossly inferior
14 quality, all of such determinations to be based upon
15 competent medical judgment and evaluations; or

16 (f) The vendor; a person with management
17 responsibility for a vendor; an officer or person owning,
18 either directly or indirectly, 5% or more of the shares of
19 stock or other evidences of ownership in a corporate
20 vendor; an owner of a sole proprietorship which is a
21 vendor; or a partner in a partnership which is a vendor,
22 either:

23 (1) was previously terminated, suspended, or
24 excluded from participation in the Illinois medical
25 assistance program, or was terminated, suspended, or
26 excluded from participation in another state or

1 federal medical assistance or health care program ~~a~~
2 ~~medical assistance program in another state that is of~~
3 ~~the same kind as the program of medical assistance~~
4 ~~provided under Article V of this Code; or~~

5 (2) was a person with management responsibility
6 for a vendor previously terminated, suspended, or
7 excluded from participation in the Illinois medical
8 assistance program, or terminated, suspended, or
9 excluded from participation in another state or
10 federal ~~a~~ medical assistance or health care program ~~in~~
11 ~~another state that is of the same kind as the program~~
12 ~~of medical assistance provided under Article V of this~~
13 ~~Code,~~ during the time of conduct which was the basis
14 for that vendor's termination, suspension, or
15 exclusion; or

16 (3) was an officer, or person owning, either
17 directly or indirectly, 5% or more of the shares of
18 stock or other evidences of ownership in a corporate or
19 limited liability company vendor previously
20 terminated, suspended, or excluded from participation
21 in the Illinois medical assistance program, or
22 terminated, suspended, or excluded from participation
23 in a state or federal medical assistance or health care
24 program ~~in another state that is of the same kind as~~
25 ~~the program of medical assistance provided under~~
26 ~~Article V of this Code,~~ during the time of conduct

1 which was the basis for that vendor's termination,
2 suspension, or exclusion; or

3 (4) was an owner of a sole proprietorship or
4 partner of a partnership previously terminated,
5 suspended, or excluded from participation in the
6 Illinois medical assistance program, or terminated,
7 suspended, or excluded from participation in a state or
8 federal medical assistance or health care program ~~in~~
9 ~~another state that is of the same kind as the program~~
10 ~~of medical assistance provided under Article V of this~~
11 ~~Code,~~ during the time of conduct which was the basis
12 for that vendor's termination, suspension, or
13 exclusion; or

14 (f-1) Such vendor has a delinquent debt owed to the
15 Illinois Department; or

16 (g) The vendor; a person with management
17 responsibility for a vendor; an officer or person owning,
18 either directly or indirectly, 5% or more of the shares of
19 stock or other evidences of ownership in a corporate or
20 limited liability company vendor; an owner of a sole
21 proprietorship which is a vendor; or a partner in a
22 partnership which is a vendor, either:

23 (1) has engaged in practices prohibited by
24 applicable federal or State law or regulation ~~relating~~
25 ~~to the medical assistance program;~~ or

26 (2) was a person with management responsibility

1 for a vendor at the time that such vendor engaged in
2 practices prohibited by applicable federal or State
3 law or regulation ~~relating to the medical assistance~~
4 ~~program~~; or

5 (3) was an officer, or person owning, either
6 directly or indirectly, 5% or more of the shares of
7 stock or other evidences of ownership in a vendor at
8 the time such vendor engaged in practices prohibited by
9 applicable federal or State law or regulation ~~relating~~
10 ~~to the medical assistance program~~; or

11 (4) was an owner of a sole proprietorship or
12 partner of a partnership which was a vendor at the time
13 such vendor engaged in practices prohibited by
14 applicable federal or State law or regulation ~~relating~~
15 ~~to the medical assistance program~~; or

16 (h) The direct or indirect ownership of the vendor
17 (including the ownership of a vendor that is a sole
18 proprietorship, a partner's interest in a vendor that is a
19 partnership, or ownership of 5% or more of the shares of
20 stock or other evidences of ownership in a corporate
21 vendor) has been transferred by an individual who is
22 terminated, suspended, or excluded or barred from
23 participating as a vendor to the individual's spouse,
24 child, brother, sister, parent, grandparent, grandchild,
25 uncle, aunt, niece, nephew, cousin, or relative by
26 marriage.

1 (A-5) The Illinois Department may deny, suspend, or
2 terminate the eligibility of any person, firm, corporation,
3 association, agency, institution, or other legal entity to
4 participate as a vendor of goods or services to recipients
5 under the medical assistance program under Article V, or may
6 exclude any such person or entity from participation as such a
7 vendor, if, after reasonable notice and opportunity for a
8 hearing, the Illinois Department finds that the vendor; a
9 person with management responsibility for a vendor; an officer
10 or person owning, either directly or indirectly, 5% or more of
11 the shares of stock or other evidences of ownership in a
12 corporate vendor; an owner of a sole proprietorship that is a
13 vendor; or a partner in a partnership that is a vendor has been
14 convicted of an ~~a felony~~ offense based on fraud or willful
15 misrepresentation related to any of the following:

16 (1) The medical assistance program under Article V of
17 this Code.

18 (2) A medical assistance or health care program in
19 another state ~~that is of the same kind as the program of~~
20 ~~medical assistance provided under Article V of this Code.~~

21 (3) The Medicare program under Title XVIII of the
22 Social Security Act.

23 (4) The provision of health care services.

24 (5) A violation of this Code, as provided in Article
25 VIIIA, or another state or federal medical assistance
26 program or health care program.

1 (A-10) The Illinois Department may deny, suspend, or
2 terminate the eligibility of any person, firm, corporation,
3 association, agency, institution, or other legal entity to
4 participate as a vendor of goods or services to recipients
5 under the medical assistance program under Article V, or may
6 exclude any such person or entity from participation as such a
7 vendor, if, after reasonable notice and opportunity for a
8 hearing, the Illinois Department finds that (i) the vendor,
9 (ii) a person with management responsibility for a vendor,
10 (iii) an officer or person owning, either directly or
11 indirectly, 5% or more of the shares of stock or other
12 evidences of ownership in a corporate vendor, (iv) an owner of
13 a sole proprietorship that is a vendor, or (v) a partner in a
14 partnership that is a vendor has been convicted of an ~~a felony~~
15 offense related to any of the following:

16 (1) Murder.

17 (2) A Class X felony under the Criminal Code of 1961.

18 (3) Sexual misconduct that may subject recipients to an
19 undue risk of harm.

20 (4) A criminal offense that may subject recipients to
21 an undue risk of harm.

22 (5) A crime of fraud or dishonesty.

23 (6) A crime involving a controlled substance.

24 (7) A misdemeanor relating to fraud, theft,
25 embezzlement, breach of fiduciary responsibility, or other
26 financial misconduct related to a health care program.

1 (A-15) The Illinois Department may deny the eligibility of
2 any person, firm, corporation, association, agency,
3 institution, or other legal entity to participate as a vendor
4 of goods or services to recipients under the medical assistance
5 program under Article V if, after reasonable notice and
6 opportunity for a hearing, the Illinois Department finds:

7 (1) The applicant or any person with management
8 responsibility for the applicant; an officer or member of
9 the board of directors of an applicant; an entity owning
10 (directly or indirectly) 5% or more of the shares of stock
11 or other evidences of ownership in a corporate vendor
12 applicant; an owner of a sole proprietorship applicant; a
13 partner in a partnership applicant; or a technical or other
14 advisor to an applicant has a debt owed to the Illinois
15 Department, and no payment arrangements acceptable to the
16 Illinois Department have been made by the applicant.

17 (2) The applicant or any person with management
18 responsibility for the applicant; an officer or member of
19 the board of directors of an applicant; an entity owning
20 (directly or indirectly) 5% or more of the shares of stock
21 or other evidences of ownership in a corporate vendor
22 applicant; an owner of a sole proprietorship applicant; a
23 partner in a partnership vendor applicant; or a technical
24 or other advisor to an applicant was (i) a person with
25 management responsibility, (ii) an officer or member of the
26 board of directors of an applicant, (iii) an entity owning

1 (directly or indirectly) 5% or more of the shares of stock
2 or other evidences of ownership in a corporate vendor, (iv)
3 an owner of a sole proprietorship, (v) a partner in a
4 partnership vendor, (vi) a technical or other advisor to a
5 vendor, during a period of time where the conduct of that
6 vendor resulted in a debt owed to the Illinois Department,
7 and no payment arrangements acceptable to the Illinois
8 Department have been made by that vendor.

9 (3) There is a credible allegation of the use,
10 transfer, or lease of assets of any kind to an applicant
11 from a current or prior vendor who has a debt owed to the
12 Illinois Department, no payment arrangements acceptable to
13 the Illinois Department have been made by that vendor or
14 the vendor's alternate payee, and the applicant knows or
15 should have known of such debt.

16 (4) There is a credible allegation of a transfer of
17 management responsibilities, or direct or indirect
18 ownership, to an applicant from a current or prior vendor
19 who has a debt owed to the Illinois Department, and no
20 payment arrangements acceptable to the Illinois Department
21 have been made by that vendor or the vendor's alternate
22 payee, and the applicant knows or should have known of such
23 debt.

24 (5) There is a credible allegation of the use,
25 transfer, or lease of assets of any kind to an applicant
26 who is a spouse, child, brother, sister, parent,

1 grandparent, grandchild, uncle, aunt, niece, relative by
2 marriage, nephew, cousin, or relative of a current or prior
3 vendor who has a debt owed to the Illinois Department and
4 no payment arrangements acceptable to the Illinois
5 Department have been made.

6 (6) There is a credible allegation that the applicant's
7 previous affiliations with a provider of medical services
8 that has an uncollected debt, a provider that has been or
9 is subject to a payment suspension under a federal health
10 care program, or a provider that has been previously
11 excluded from participation in the medical assistance
12 program, poses a risk of fraud, waste, or abuse to the
13 Illinois Department.

14 As used in this subsection, "credible allegation" is
15 defined to include an allegation from any source, including,
16 but not limited to, fraud hotline complaints, claims data
17 mining, patterns identified through provider audits, civil
18 actions filed under the False Claims Act, and law enforcement
19 investigations. An allegation is considered to be credible when
20 it has indicia of reliability.

21 (B) The Illinois Department shall deny, suspend or
22 terminate the eligibility of any person, firm, corporation,
23 association, agency, institution or other legal entity to
24 participate as a vendor of goods or services to recipients
25 under the medical assistance program under Article V, or may
26 exclude any such person or entity from participation as such a

1 vendor:

2 (1) immediately, if such vendor is not properly
3 licensed, certified, or authorized;

4 (2) within 30 days of the date when such vendor's
5 professional license, certification or other authorization
6 has been refused renewal, restricted, ~~or has been~~ revoked,
7 suspended, or otherwise terminated; or

8 (3) if such vendor has been convicted of a violation of
9 this Code, as provided in Article VIII A.

10 (C) Upon termination, suspension, or exclusion of a vendor
11 of goods or services from participation in the medical
12 assistance program authorized by this Article, a person with
13 management responsibility for such vendor during the time of
14 any conduct which served as the basis for that vendor's
15 termination, suspension, or exclusion is barred from
16 participation in the medical assistance program.

17 Upon termination, suspension, or exclusion of a corporate
18 vendor, the officers and persons owning, directly or
19 indirectly, 5% or more of the shares of stock or other
20 evidences of ownership in the vendor during the time of any
21 conduct which served as the basis for that vendor's
22 termination, suspension, or exclusion are barred from
23 participation in the medical assistance program. A person who
24 owns, directly or indirectly, 5% or more of the shares of stock
25 or other evidences of ownership in a terminated, suspended, or
26 excluded ~~corporate~~ vendor may not transfer his or her ownership

1 interest in that vendor to his or her spouse, child, brother,
2 sister, parent, grandparent, grandchild, uncle, aunt, niece,
3 nephew, cousin, or relative by marriage.

4 Upon termination, suspension, or exclusion of a sole
5 proprietorship or partnership, the owner or partners during the
6 time of any conduct which served as the basis for that vendor's
7 termination, suspension, or exclusion are barred from
8 participation in the medical assistance program. The owner of a
9 terminated, suspended, or excluded vendor that is a sole
10 proprietorship, and a partner in a terminated, suspended, or
11 excluded vendor that is a partnership, may not transfer his or
12 her ownership or partnership interest in that vendor to his or
13 her spouse, child, brother, sister, parent, grandparent,
14 grandchild, uncle, aunt, niece, nephew, cousin, or relative by
15 marriage.

16 A person who owns, directly or indirectly, 5% or more of
17 the shares of stock or other evidences of ownership in a
18 corporate or limited liability company vendor who owes a debt
19 to the Department, if that vendor has not made payment
20 arrangements acceptable to the Department, shall not transfer
21 his or her ownership interest in that vendor, or vendor assets
22 of any kind, to his or her spouse, child, brother, sister,
23 parent, grandparent, grandchild, uncle, aunt, niece, nephew,
24 cousin, or relative by marriage.

25 Rules adopted by the Illinois Department to implement these
26 provisions shall specifically include a definition of the term

1 "management responsibility" as used in this Section. Such
2 definition shall include, but not be limited to, typical job
3 titles, and duties and descriptions which will be considered as
4 within the definition of individuals with management
5 responsibility for a provider.

6 A vendor or a prior vendor who has been terminated,
7 excluded, or suspended from the medical assistance program, or
8 from another state or federal medical assistance or health care
9 program, and any individual currently or previously barred from
10 the medical assistance program, or from another state or
11 federal medical assistance or health care program, as a result
12 of being an officer or a person owning, directly, or
13 indirectly, 5% or more of the shares of stock or other
14 evidences of ownership in a corporate or limited liability
15 company vendor during the time of any conduct which served as
16 the basis for that vendor's termination, suspension, or
17 exclusion, may be required to post a surety bond as part of a
18 condition of enrollment or participation in the medical
19 assistance program. The Illinois Department shall establish,
20 by rule, the criteria and requirements for determining when a
21 surety bond must be posted and the value of the bond.

22 A vendor or a prior vendor who has a debt owed to the
23 Illinois Department and any individual currently or previously
24 barred from the medical assistance program, or from another
25 state or federal medical assistance or health care program, as
26 a result of being an officer or a person owning, directly or

1 indirectly, 5% or more of the shares of stock or other
2 evidences of ownership in that corporate or limited liability
3 company vendor during the time of any conduct which served as
4 the basis for the debt, may be required to post a surety bond
5 as part of a condition of enrollment or participation in the
6 medical assistance program. The Illinois Department shall
7 establish, by rule, the criteria and requirements for
8 determining when a surety bond must be posted and the value of
9 the bond.

10 (D) If a vendor has been suspended from the medical
11 assistance program under Article V of the Code, the Director
12 may require that such vendor correct any deficiencies which
13 served as the basis for the suspension. The Director shall
14 specify in the suspension order a specific period of time,
15 which shall not exceed one year from the date of the order,
16 during which a suspended vendor shall not be eligible to
17 participate. At the conclusion of the period of suspension the
18 Director shall reinstate such vendor, unless he finds that such
19 vendor has not corrected deficiencies upon which the suspension
20 was based.

21 If a vendor has been terminated, suspended, or excluded
22 from the medical assistance program under Article V, such
23 vendor shall be barred from participation for at least one
24 year, except that if a vendor has been terminated, suspended,
25 or excluded based on a conviction of a violation of Article
26 VIIIA or a conviction of a felony based on fraud or a willful

1 misrepresentation related to (i) the medical assistance
2 program under Article V, (ii) a federal or another state's
3 medical assistance or health care program ~~in another state that~~
4 ~~is of the kind provided under Article V, (iii) the Medicare~~
5 ~~program under Title XVIII of the Social Security Act, or (iii)~~
6 ~~(iv)~~ the provision of health care services, then the vendor
7 shall be barred from participation for 5 years or for the
8 length of the vendor's sentence for that conviction, whichever
9 is longer. At the end of one year a vendor who has been
10 terminated, suspended, or excluded may apply for reinstatement
11 to the program. Upon proper application to be reinstated such
12 vendor may be deemed eligible by the Director providing that
13 such vendor meets the requirements for eligibility under this
14 Code. If such vendor is deemed not eligible for reinstatement,
15 he shall be barred from again applying for reinstatement for
16 one year from the date his application for reinstatement is
17 denied.

18 A vendor whose termination, suspension, or exclusion from
19 participation in the Illinois medical assistance program under
20 Article V was based solely on an action by a governmental
21 entity other than the Illinois Department may, upon
22 reinstatement by that governmental entity or upon reversal of
23 the termination, suspension, or exclusion, apply for
24 rescission of the termination, suspension, or exclusion from
25 participation in the Illinois medical assistance program. Upon
26 proper application for rescission, the vendor may be deemed

1 eligible by the Director if the vendor meets the requirements
2 for eligibility under this Code.

3 If a vendor has been terminated, suspended, or excluded and
4 reinstated to the medical assistance program under Article V
5 and the vendor is terminated, suspended, or excluded a second
6 or subsequent time from the medical assistance program, the
7 vendor shall be barred from participation for at least 2 years,
8 except that if a vendor has been terminated, suspended, or
9 excluded a second time based on a conviction of a violation of
10 Article VIIIA or a conviction of a felony based on fraud or a
11 willful misrepresentation related to (i) the medical
12 assistance program under Article V, (ii) a federal or another
13 state's medical assistance or health care program ~~in another~~
14 ~~state that is of the kind provided under Article V, (iii) the~~
15 ~~Medicare program under Title XVIII of the Social Security Act,~~
16 or (iii) ~~(iv)~~ the provision of health care services, then the
17 vendor shall be barred from participation for life. At the end
18 of 2 years, a vendor who has been terminated, suspended, or
19 excluded may apply for reinstatement to the program. Upon
20 application to be reinstated, the vendor may be deemed eligible
21 if the vendor meets the requirements for eligibility under this
22 Code. If the vendor is deemed not eligible for reinstatement,
23 the vendor shall be barred from again applying for
24 reinstatement for 2 years from the date the vendor's
25 application for reinstatement is denied.

26 (E) The Illinois Department may recover money improperly or

1 erroneously paid, or overpayments, either by setoff, crediting
2 against future billings or by requiring direct repayment to the
3 Illinois Department. The Illinois Department may suspend or
4 deny payment, in whole or in part, if such payment would be
5 improper or erroneous or would otherwise result in overpayment.

6 (1) Payments may be suspended, denied, or recovered
7 from a vendor or alternate payee: (i) for services rendered
8 in violation of the Illinois Department's provider
9 notices, statutes, rules, and regulations; (ii) for
10 services rendered in violation of the terms and conditions
11 prescribed by the Illinois Department in its vendor
12 agreement; (iii) for any vendor who fails to grant the
13 Office of Inspector General timely access to full and
14 complete records, including, but not limited to, records
15 relating to recipients under the medical assistance
16 program for the most recent 6 years, in accordance with
17 Section 140.28 of Title 89 of the Illinois Administrative
18 Code, and other information for the purpose of audits,
19 investigations, or other program integrity functions,
20 after reasonable written request by the Inspector General;
21 this subsection (E) does not require vendors to make
22 available the medical records of patients for whom services
23 are not reimbursed under this Code or to provide access to
24 medical records more than 6 years old; (iv) when the vendor
25 has knowingly made, or caused to be made, any false
26 statement or representation of a material fact in

1 connection with the administration of the medical
2 assistance program; or (v) when the vendor previously
3 rendered services while terminated, suspended, or excluded
4 from participation in the medical assistance program or
5 while terminated or excluded from participation in another
6 state or federal medical assistance or health care program.

7 (2) Notwithstanding any other provision of law, if a
8 vendor has the same taxpayer identification number
9 (assigned under Section 6109 of the Internal Revenue Code
10 of 1986) as is assigned to a vendor with past-due financial
11 obligations to the Illinois Department, the Illinois
12 Department may make any necessary adjustments to payments
13 to that vendor in order to satisfy any past-due
14 obligations, regardless of whether the vendor is assigned a
15 different billing number under the medical assistance
16 program.

17 If the Illinois Department establishes through an
18 administrative hearing that the overpayments resulted from the
19 vendor or alternate payee knowingly willfully making, using, or
20 causing to be made or used, a false record or statement to
21 obtain payment or other benefit from ~~or misrepresentation of a~~
22 ~~material fact in connection with billings and payments under~~
23 the medical assistance program under Article V, the Department
24 may recover interest on the amount of the payment or other
25 benefit ~~overpayments~~ at the rate of 5% per annum. In addition
26 to any other penalties that may be prescribed by law, such a

1 vendor or alternate payee shall be subject to civil penalties
2 consisting of an amount not to exceed 3 times the amount of
3 payment or other benefit resulting from each such false record
4 or statement, and the sum of \$2,000 for each such false record
5 or statement for payment or other benefit. For purposes of this
6 paragraph, "knowingly" "willfully" means that a vendor or
7 alternate payee with respect to information: (i) has ~~person~~
8 ~~makes a statement or representation with~~ actual knowledge of
9 the information, (ii) acts in deliberate ignorance of the truth
10 or falsity of the information, or (iii) acts in reckless
11 disregard of the truth or falsity of the information. No proof
12 of specific intent to defraud is required. ~~that it was false,~~
13 ~~or makes a statement or representation with knowledge of facts~~
14 ~~or information that would cause one to be aware that the~~
15 ~~statement or representation was false when made.~~

16 (F) The Illinois Department may withhold payments to any
17 vendor or alternate payee prior to or during the pendency of
18 any audit or proceeding under this Section, and through the
19 pendency of any administrative appeal or administrative review
20 by any court proceeding. The Illinois Department shall state by
21 rule with as much specificity as practicable the conditions
22 under which payments will not be withheld ~~during the pendency~~
23 ~~of any proceeding~~ under this Section. Payments may be denied
24 for bills submitted with service dates occurring during the
25 pendency of a proceeding, after a final decision has been
26 rendered, or after the conclusion of any administrative appeal,

1 where the final administrative decision is to terminate,
2 exclude, or suspend eligibility to participate in the medical
3 assistance program. The Illinois Department shall state by rule
4 with as much specificity as practicable the conditions under
5 which payments will not be denied for such bills. The Illinois
6 Department shall state by rule a process and criteria by which
7 a vendor or alternate payee may request full or partial release
8 of payments withheld under this subsection. The Department must
9 complete a proceeding under this Section in a timely manner.

10 Notwithstanding recovery allowed under subsection (E) or
11 this subsection (F), the Illinois Department may withhold
12 payments to any vendor or alternate payee who is not properly
13 licensed, certified, or in compliance with State or federal
14 agency regulations. Payments may be denied for bills submitted
15 with service dates occurring during the period of time that a
16 vendor is not properly licensed, certified, or in compliance
17 with State or federal regulations. Facilities licensed under
18 the Nursing Home Care Act shall have payments denied or
19 withheld pursuant to subsection (I) of this Section.

20 (F-5) The Illinois Department may temporarily withhold
21 payments to a vendor or alternate payee if any of the following
22 individuals have been indicted or otherwise charged under a law
23 of the United States or this or any other state with an a
24 ~~felony~~ offense that is based on alleged fraud or willful
25 misrepresentation on the part of the individual related to (i)
26 the medical assistance program under Article V of this Code,

1 (ii) a federal or another state's medical assistance or health
2 care program ~~provided in another state which is of the kind~~
3 ~~provided under Article V of this Code, (iii) the Medicare~~
4 ~~program under Title XVIII of the Social Security Act, or (iii)~~
5 ~~(iv)~~ the provision of health care services:

6 (1) If the vendor or alternate payee is a corporation:
7 an officer of the corporation or an individual who owns,
8 either directly or indirectly, 5% or more of the shares of
9 stock or other evidence of ownership of the corporation.

10 (2) If the vendor is a sole proprietorship: the owner
11 of the sole proprietorship.

12 (3) If the vendor or alternate payee is a partnership:
13 a partner in the partnership.

14 (4) If the vendor or alternate payee is any other
15 business entity authorized by law to transact business in
16 this State: an officer of the entity or an individual who
17 owns, either directly or indirectly, 5% or more of the
18 evidences of ownership of the entity.

19 If the Illinois Department withholds payments to a vendor
20 or alternate payee under this subsection, the Department shall
21 not release those payments to the vendor or alternate payee
22 while any criminal proceeding related to the indictment or
23 charge is pending unless the Department determines that there
24 is good cause to release the payments before completion of the
25 proceeding. If the indictment or charge results in the
26 individual's conviction, the Illinois Department shall retain

1 all withheld payments, which shall be considered forfeited to
2 the Department. If the indictment or charge does not result in
3 the individual's conviction, the Illinois Department shall
4 release to the vendor or alternate payee all withheld payments.

5 (F-10) If the Illinois Department establishes that the
6 vendor or alternate payee owes a debt to the Illinois
7 Department, and the vendor or alternate payee subsequently
8 fails to pay or make satisfactory payment arrangements with the
9 Illinois Department for the debt owed, the Illinois Department
10 may seek all remedies available under the law of this State to
11 recover the debt, including, but not limited to, wage
12 garnishment or the filing of claims or liens against the vendor
13 or alternate payee.

14 (F-15) Enforcement of judgment.

15 (1) Any fine, recovery amount, other sanction, or costs
16 imposed, or part of any fine, recovery amount, other
17 sanction, or cost imposed, remaining unpaid after the
18 exhaustion of or the failure to exhaust judicial review
19 procedures under the Illinois Administrative Review Law is
20 a debt due and owing the State and may be collected using
21 all remedies available under the law.

22 (2) After expiration of the period in which judicial
23 review under the Illinois Administrative Review Law may be
24 sought for a final administrative decision, unless stayed
25 by a court of competent jurisdiction, the findings,
26 decision, and order of the Director may be enforced in the

1 same manner as a judgment entered by a court of competent
2 jurisdiction.

3 (3) In any case in which any person or entity has
4 failed to comply with a judgment ordering or imposing any
5 fine or other sanction, any expenses incurred by the
6 Illinois Department to enforce the judgment, including,
7 but not limited to, attorney's fees, court costs, and costs
8 related to property demolition or foreclosure, after they
9 are fixed by a court of competent jurisdiction or the
10 Director, shall be a debt due and owing the State and may
11 be collected in accordance with applicable law. Prior to
12 any expenses being fixed by a final administrative decision
13 pursuant to this subsection (F-15), the Illinois
14 Department shall provide notice to the individual or entity
15 that states that the individual or entity shall appear at a
16 hearing before the administrative hearing officer to
17 determine whether the individual or entity has failed to
18 comply with the judgment. The notice shall set the date for
19 such a hearing, which shall not be less than 7 days from
20 the date that notice is served. If notice is served by
21 mail, the 7-day period shall begin to run on the date that
22 the notice was deposited in the mail.

23 (4) Upon being recorded in the manner required by
24 Article XII of the Code of Civil Procedure or by the
25 Uniform Commercial Code, a lien shall be imposed on the
26 real estate or personal estate, or both, of the individual

1 or entity in the amount of any debt due and owing the State
2 under this Section. The lien may be enforced in the same
3 manner as a judgment of a court of competent jurisdiction.
4 A lien shall attach to all property and assets of such
5 person, firm, corporation, association, agency,
6 institution, or other legal entity until the judgment is
7 satisfied.

8 (5) The Director may set aside any judgment entered by
9 default and set a new hearing date upon a petition filed at
10 any time (i) if the petitioner's failure to appear at the
11 hearing was for good cause, or (ii) if the petitioner
12 established that the Department did not provide proper
13 service of process. If any judgment is set aside pursuant
14 to this paragraph (5), the hearing officer shall have
15 authority to enter an order extinguishing any lien which
16 has been recorded for any debt due and owing the Illinois
17 Department as a result of the vacated default judgment.

18 (G) The provisions of the Administrative Review Law, as now
19 or hereafter amended, and the rules adopted pursuant thereto,
20 shall apply to and govern all proceedings for the judicial
21 review of final administrative decisions of the Illinois
22 Department under this Section. The term "administrative
23 decision" is defined as in Section 3-101 of the Code of Civil
24 Procedure.

25 (G-5) Vendors who pose a risk of fraud, waste, abuse, or
26 harm ~~Non-emergency transportation.~~

1 (1) Notwithstanding any other provision in this
2 Section, ~~for non-emergency transportation vendors,~~ the
3 Department may terminate, suspend, or exclude vendors who
4 pose a risk of fraud, waste, abuse, or harm ~~the vendor~~ from
5 participation in the medical assistance program prior to an
6 evidentiary hearing but after reasonable notice and
7 opportunity to respond as established by the Department by
8 rule.

9 (2) Vendors who pose a risk of fraud, waste, abuse, or
10 harm ~~of non-emergency medical transportation services, as~~
11 ~~defined by the Department by rule,~~ shall submit to a
12 fingerprint-based criminal background check on current and
13 future information available in the State system and
14 current information available through the Federal Bureau
15 of Investigation's system by submitting all necessary fees
16 and information in the form and manner prescribed by the
17 Department of State Police. The following individuals
18 shall be subject to the check:

19 (A) In the case of a vendor that is a corporation,
20 every shareholder who owns, directly or indirectly, 5%
21 or more of the outstanding shares of the corporation.

22 (B) In the case of a vendor that is a partnership,
23 every partner.

24 (C) In the case of a vendor that is a sole
25 proprietorship, the sole proprietor.

26 (D) Each officer or manager of the vendor.

1 Each such vendor shall be responsible for payment of
2 the cost of the criminal background check.

3 (3) Vendors who pose a risk of fraud, waste, abuse, or
4 harm of non-emergency medical transportation services may
5 be required to post a surety bond. The Department shall
6 establish, by rule, the criteria and requirements for
7 determining when a surety bond must be posted and the value
8 of the bond.

9 (4) The Department, or its agents, may refuse to accept
10 requests for authorization from specific vendors who pose a
11 risk of fraud, waste, abuse, or harm non-emergency
12 ~~transportation authorizations~~, including prior-approval
13 and post-approval requests, ~~for a specific non-emergency~~
14 ~~transportation vendor~~ if:

15 (A) the Department has initiated a notice of
16 termination, suspension, or exclusion of the vendor
17 from participation in the medical assistance program;
18 or

19 (B) the Department has issued notification of its
20 withholding of payments pursuant to subsection (F-5)
21 of this Section; or

22 (C) the Department has issued a notification of its
23 withholding of payments due to reliable evidence of
24 fraud or willful misrepresentation pending
25 investigation.

26 (5) As used in this subsection, the following terms are

1 defined as follows:

2 (A) "Fraud" means an intentional deception or
3 misrepresentation made by a person with the knowledge
4 that the deception could result in some unauthorized
5 benefit to himself or herself or some other person. It
6 includes any act that constitutes fraud under
7 applicable federal or State law.

8 (B) "Abuse" means provider practices that are
9 inconsistent with sound fiscal, business, or medical
10 practices and that result in an unnecessary cost to the
11 medical assistance program or in reimbursement for
12 services that are not medically necessary or that fail
13 to meet professionally recognized standards for health
14 care. It also includes recipient practices that result
15 in unnecessary cost to the medical assistance program.
16 Abuse does not include diagnostic or therapeutic
17 measures conducted primarily as a safeguard against
18 possible vendor liability.

19 (C) "Waste" means the unintentional misuse of
20 medical assistance resources, resulting in unnecessary
21 cost to the medical assistance program. Waste does not
22 include diagnostic or therapeutic measures conducted
23 primarily as a safeguard against possible vendor
24 liability.

25 (D) "Harm" means physical, mental, or monetary
26 damage to recipients or to the medical assistance

1 program.

2 (G-6) The Illinois Department, upon making a determination
3 based upon information in the possession of the Illinois
4 Department that continuation of participation in the medical
5 assistance program by a vendor would constitute an immediate
6 danger to the public, may immediately suspend such vendor's
7 participation in the medical assistance program without a
8 hearing. In instances in which the Illinois Department
9 immediately suspends the medical assistance program
10 participation of a vendor under this Section, a hearing upon
11 the vendor's participation must be convened by the Illinois
12 Department within 15 days after such suspension and completed
13 without appreciable delay. Such hearing shall be held to
14 determine whether to recommend to the Director that the
15 vendor's medical assistance program participation be denied,
16 terminated, suspended, placed on provisional status, or
17 reinstated. In the hearing, any evidence relevant to the vendor
18 constituting an immediate danger to the public may be
19 introduced against such vendor; provided, however, that the
20 vendor, or his or her counsel, shall have the opportunity to
21 discredit, impeach, and submit evidence rebutting such
22 evidence.

23 (H) Nothing contained in this Code shall in any way limit
24 or otherwise impair the authority or power of any State agency
25 responsible for licensing of vendors.

26 (I) Based on a finding of noncompliance on the part of a

1 nursing home with any requirement for certification under Title
2 XVIII or XIX of the Social Security Act (42 U.S.C. Sec. 1395 et
3 seq. or 42 U.S.C. Sec. 1396 et seq.), the Illinois Department
4 may impose one or more of the following remedies after notice
5 to the facility:

6 (1) Termination of the provider agreement.

7 (2) Temporary management.

8 (3) Denial of payment for new admissions.

9 (4) Civil money penalties.

10 (5) Closure of the facility in emergency situations or
11 transfer of residents, or both.

12 (6) State monitoring.

13 (7) Denial of all payments when the U.S. Department of
14 Health and Human Services ~~Health Care Finance~~
15 ~~Administration~~ has imposed this sanction.

16 The Illinois Department shall by rule establish criteria
17 governing continued payments to a nursing facility subsequent
18 to termination of the facility's provider agreement if, in the
19 sole discretion of the Illinois Department, circumstances
20 affecting the health, safety, and welfare of the facility's
21 residents require those continued payments. The Illinois
22 Department may condition those continued payments on the
23 appointment of temporary management, sale of the facility to
24 new owners or operators, or other arrangements that the
25 Illinois Department determines best serve the needs of the
26 facility's residents.

1 Except in the case of a facility that has a right to a
2 hearing on the finding of noncompliance before an agency of the
3 federal government, a facility may request a hearing before a
4 State agency on any finding of noncompliance within 60 days
5 after the notice of the intent to impose a remedy. Except in
6 the case of civil money penalties, a request for a hearing
7 shall not delay imposition of the penalty. The choice of
8 remedies is not appealable at a hearing. The level of
9 noncompliance may be challenged only in the case of a civil
10 money penalty. The Illinois Department shall provide by rule
11 for the State agency that will conduct the evidentiary
12 hearings.

13 The Illinois Department may collect interest on unpaid
14 civil money penalties.

15 The Illinois Department may adopt all rules necessary to
16 implement this subsection (I).

17 (J) The Illinois Department, by rule, may permit individual
18 practitioners to designate that Department payments that may be
19 due the practitioner be made to an alternate payee or alternate
20 payees.

21 (a) Such alternate payee or alternate payees shall be
22 required to register as an alternate payee in the Medical
23 Assistance Program with the Illinois Department.

24 (b) If a practitioner designates an alternate payee,
25 the alternate payee and practitioner shall be jointly and
26 severally liable to the Department for payments made to the

1 alternate payee. Pursuant to subsection (E) of this
2 Section, any Department action to suspend or deny payment
3 or recover money or overpayments from an alternate payee
4 shall be subject to an administrative hearing.

5 (c) Registration as an alternate payee or alternate
6 payees in the Illinois Medical Assistance Program shall be
7 conditional. At any time, the Illinois Department may deny
8 or cancel any alternate payee's registration in the
9 Illinois Medical Assistance Program without cause. Any
10 such denial or cancellation is not subject to an
11 administrative hearing.

12 (d) The Illinois Department may seek a revocation of
13 any alternate payee, and all owners, officers, and
14 individuals with management responsibility for such
15 alternate payee shall be permanently prohibited from
16 participating as an owner, an officer, or an individual
17 with management responsibility with an alternate payee in
18 the Illinois Medical Assistance Program, if after
19 reasonable notice and opportunity for a hearing the
20 Illinois Department finds that:

21 (1) the alternate payee is not complying with the
22 Department's policy or rules and regulations, or with
23 the terms and conditions prescribed by the Illinois
24 Department in its alternate payee registration
25 agreement; or

26 (2) the alternate payee has failed to keep or make

1 available for inspection, audit, or copying, after
2 receiving a written request from the Illinois
3 Department, such records regarding payments claimed as
4 an alternate payee; or

5 (3) the alternate payee has failed to furnish any
6 information requested by the Illinois Department
7 regarding payments claimed as an alternate payee; or

8 (4) the alternate payee has knowingly made, or
9 caused to be made, any false statement or
10 representation of a material fact in connection with
11 the administration of the Illinois Medical Assistance
12 Program; or

13 (5) the alternate payee, a person with management
14 responsibility for an alternate payee, an officer or
15 person owning, either directly or indirectly, 5% or
16 more of the shares of stock or other evidences of
17 ownership in a corporate alternate payee, or a partner
18 in a partnership which is an alternate payee:

19 (a) was previously terminated, suspended, or
20 excluded from participation as a vendor in the
21 Illinois Medical Assistance Program, or was
22 previously revoked as an alternate payee in the
23 Illinois Medical Assistance Program, or was
24 terminated, suspended, or excluded from
25 participation as a vendor in a medical assistance
26 program in another state that is of the same kind

1 as the program of medical assistance provided
2 under Article V of this Code; or

3 (b) was a person with management
4 responsibility for a vendor previously terminated,
5 suspended, or excluded from participation as a
6 vendor in the Illinois Medical Assistance Program,
7 or was previously revoked as an alternate payee in
8 the Illinois Medical Assistance Program, or was
9 terminated, suspended, or excluded from
10 participation as a vendor in a medical assistance
11 program in another state that is of the same kind
12 as the program of medical assistance provided
13 under Article V of this Code, during the time of
14 conduct which was the basis for that vendor's
15 termination, suspension, or exclusion or alternate
16 payee's revocation; or

17 (c) was an officer, or person owning, either
18 directly or indirectly, 5% or more of the shares of
19 stock or other evidences of ownership in a
20 corporate vendor previously terminated, suspended,
21 or excluded from participation as a vendor in the
22 Illinois Medical Assistance Program, or was
23 previously revoked as an alternate payee in the
24 Illinois Medical Assistance Program, or was
25 terminated, suspended, or excluded from
26 participation as a vendor in a medical assistance

1 program in another state that is of the same kind
2 as the program of medical assistance provided
3 under Article V of this Code, during the time of
4 conduct which was the basis for that vendor's
5 termination, suspension, or exclusion; or

6 (d) was an owner of a sole proprietorship or
7 partner in a partnership previously terminated, suspended, or excluded from participation as a
8 vendor in the Illinois Medical Assistance Program,
9 or was previously revoked as an alternate payee in
10 the Illinois Medical Assistance Program, or was
11 terminated, suspended, or excluded from
12 participation as a vendor in a medical assistance
13 program in another state that is of the same kind
14 as the program of medical assistance provided
15 under Article V of this Code, during the time of
16 conduct which was the basis for that vendor's
17 termination, suspension, or exclusion or alternate
18 payee's revocation; or

19 (6) the alternate payee, a person with management
20 responsibility for an alternate payee, an officer or
21 person owning, either directly or indirectly, 5% or
22 more of the shares of stock or other evidences of
23 ownership in a corporate alternate payee, or a partner
24 in a partnership which is an alternate payee:

25 (a) has engaged in conduct prohibited by
26

1 applicable federal or State law or regulation
2 relating to the Illinois Medical Assistance
3 Program; or

4 (b) was a person with management
5 responsibility for a vendor or alternate payee at
6 the time that the vendor or alternate payee engaged
7 in practices prohibited by applicable federal or
8 State law or regulation relating to the Illinois
9 Medical Assistance Program; or

10 (c) was an officer, or person owning, either
11 directly or indirectly, 5% or more of the shares of
12 stock or other evidences of ownership in a vendor
13 or alternate payee at the time such vendor or
14 alternate payee engaged in practices prohibited by
15 applicable federal or State law or regulation
16 relating to the Illinois Medical Assistance
17 Program; or

18 (d) was an owner of a sole proprietorship or
19 partner in a partnership which was a vendor or
20 alternate payee at the time such vendor or
21 alternate payee engaged in practices prohibited by
22 applicable federal or State law or regulation
23 relating to the Illinois Medical Assistance
24 Program; or

25 (7) the direct or indirect ownership of the vendor
26 or alternate payee (including the ownership of a vendor

1 or alternate payee that is a partner's interest in a
2 vendor or alternate payee, or ownership of 5% or more
3 of the shares of stock or other evidences of ownership
4 in a corporate vendor or alternate payee) has been
5 transferred by an individual who is terminated,
6 suspended, or excluded or barred from participating as
7 a vendor or is prohibited or revoked as an alternate
8 payee to the individual's spouse, child, brother,
9 sister, parent, grandparent, grandchild, uncle, aunt,
10 niece, nephew, cousin, or relative by marriage.

11 (K) The Illinois Department of Healthcare and Family
12 Services may withhold payments, in whole or in part, to a
13 provider or alternate payee where there is credible ~~upon~~
14 ~~receipt of~~ evidence, received from State or federal law
15 enforcement or federal oversight agencies or from the results
16 of a preliminary Department audit ~~and determined by the~~
17 ~~Department to be credible~~, that the circumstances giving rise
18 to the need for a withholding of payments may involve fraud or
19 willful misrepresentation under the Illinois Medical
20 Assistance program. The Department shall by rule define what
21 constitutes "credible" evidence for purposes of this
22 subsection. The Department may withhold payments without first
23 notifying the provider or alternate payee of its intention to
24 withhold such payments. A provider or alternate payee may
25 request a reconsideration of payment withholding, and the
26 Department must grant such a request. The Department shall

1 state by rule a process and criteria by which a provider or
2 alternate payee may request full or partial release of payments
3 withheld under this subsection. This request may be made at any
4 time after the Department first withholds such payments.

5 (a) The Illinois Department must send notice of its
6 withholding of program payments within 5 days of taking
7 such action. The notice must set forth the general
8 allegations as to the nature of the withholding action, but
9 need not disclose any specific information concerning its
10 ongoing investigation. The notice must do all of the
11 following:

12 (1) State that payments are being withheld in
13 accordance with this subsection.

14 (2) State that the withholding is for a temporary
15 period, as stated in paragraph (b) of this subsection,
16 and cite the circumstances under which withholding
17 will be terminated.

18 (3) Specify, when appropriate, which type or types
19 of Medicaid claims withholding is effective.

20 (4) Inform the provider or alternate payee of the
21 right to submit written evidence for reconsideration
22 of the withholding by the Illinois Department.

23 (5) Inform the provider or alternate payee that a
24 written request may be made to the Illinois Department
25 for full or partial release of withheld payments and
26 that such requests may be made at any time after the

1 Department first withholds such payments.

2 (b) All withholding-of-payment actions under this
3 subsection shall be temporary and shall not continue after
4 any of the following:

5 (1) The Illinois Department or the prosecuting
6 authorities determine that there is insufficient
7 evidence of fraud or willful misrepresentation by the
8 provider or alternate payee.

9 (2) Legal proceedings related to the provider's or
10 alternate payee's alleged fraud, willful
11 misrepresentation, violations of this Act, or
12 violations of the Illinois Department's administrative
13 rules are completed.

14 (3) The withholding of payments for a period of 3
15 years.

16 (c) The Illinois Department may adopt all rules
17 necessary to implement this subsection (K).

18 (K-5) The Illinois Department may withhold payments, in
19 whole or in part, to a provider or alternate payee upon
20 initiation of an audit, quality of care review, investigation
21 when there is a credible allegation of fraud, or the provider
22 or alternate payee demonstrating a clear failure to cooperate
23 with the Illinois Department such that the circumstances give
24 rise to the need for a withholding of payments. As used in this
25 subsection, "credible allegation" is defined to include an
26 allegation from any source, including, but not limited to,

1 fraud hotline complaints, claims data mining, patterns
2 identified through provider audits, civil actions filed under
3 the False Claims Act, and law enforcement investigations. An
4 allegation is considered to be credible when it has indicia of
5 reliability. The Illinois Department may withhold payments
6 without first notifying the provider or alternate payee of its
7 intention to withhold such payments. A provider or alternate
8 payee may request a hearing or a reconsideration of payment
9 withholding, and the Illinois Department must grant such a
10 request. The Illinois Department shall state by rule a process
11 and criteria by which a provider or alternate payee may request
12 a hearing or a reconsideration for the full or partial release
13 of payments withheld under this subsection. This request may be
14 made at any time after the Illinois Department first withholds
15 such payments.

16 (a) The Illinois Department must send notice of its
17 withholding of program payments within 5 days of taking
18 such action. The notice must set forth the general
19 allegations as to the nature of the withholding action but
20 need not disclose any specific information concerning its
21 ongoing investigation. The notice must do all of the
22 following:

23 (1) State that payments are being withheld in
24 accordance with this subsection.

25 (2) State that the withholding is for a temporary
26 period, as stated in paragraph (b) of this subsection,

1 and cite the circumstances under which withholding
2 will be terminated.

3 (3) Specify, when appropriate, which type or types
4 of claims are withheld.

5 (4) Inform the provider or alternate payee of the
6 right to request a hearing or a reconsideration of the
7 withholding by the Illinois Department, including the
8 ability to submit written evidence.

9 (5) Inform the provider or alternate payee that a
10 written request may be made to the Illinois Department
11 for a hearing or a reconsideration for the full or
12 partial release of withheld payments and that such
13 requests may be made at any time after the Illinois
14 Department first withholds such payments.

15 (b) All withholding of payment actions under this
16 subsection shall be temporary and shall not continue after
17 any of the following:

18 (1) The Illinois Department determines that there
19 is insufficient evidence of fraud, or the provider or
20 alternate payee demonstrates clear cooperation with
21 the Illinois Department, as determined by the Illinois
22 Department, such that the circumstances do not give
23 rise to the need for withholding of payments; or

24 (2) The withholding of payments has lasted for a
25 period in excess of 3 years.

26 (c) The Illinois Department may adopt all rules

1 necessary to implement this subsection (K-5).

2 (L) The Illinois Department shall establish a protocol to
3 enable health care providers to disclose an actual or potential
4 violation of this Section pursuant to a self-referral
5 disclosure protocol, referred to in this subsection as "the
6 protocol". The protocol shall include direction for health care
7 providers on a specific person, official, or office to whom
8 such disclosures shall be made. The Illinois Department shall
9 post information on the protocol on the Illinois Department's
10 public website. The Illinois Department may adopt rules
11 necessary to implement this subsection (L). In addition to
12 other factors that the Illinois Department finds appropriate,
13 the Illinois Department may consider a health care provider's
14 timely use or failure to use the protocol in considering the
15 provider's failure to comply with this Code.

16 (M) Notwithstanding any other provision of this Code, the
17 Illinois Department, at its discretion, may exempt an entity
18 licensed under the Nursing Home Care Act and the ID/DD
19 Community Care Act from the provisions of subsections (A-15),
20 (B), and (C) of this Section if the licensed entity is in
21 receivership.

22 (Source: P.A. 94-265, eff. 1-1-06; 94-975, eff. 6-30-06.)

23 (305 ILCS 5/12-4.38)

24 Sec. 12-4.38. Special FamilyCare provisions. ~~(a)~~ The
25 Department of Healthcare and Family Services may submit to the

1 Comptroller, and the Comptroller is authorized to pay, on
2 behalf of persons enrolled in the FamilyCare Program, claims
3 for services rendered to an enrollee during the period
4 beginning October 1, 2007, and ending on the effective date of
5 any rules adopted to implement the provisions of this
6 amendatory Act of the 96th General Assembly. The authorization
7 for payment of claims applies only to bona fide claims for
8 payment for services rendered. Any claim for payment which is
9 authorized pursuant to the provisions of this amendatory Act of
10 the 96th General Assembly must adhere to all other applicable
11 rules, regulations, and requirements.

12 ~~(b) Each person enrolled in the FamilyCare Program as of~~
13 ~~the effective date of this amendatory Act of the 96th General~~
14 ~~Assembly whose income exceeds 185% of the Federal Poverty~~
15 ~~Level, but is not more than 400% of the Federal Poverty Level,~~
16 ~~may remain enrolled in the FamilyCare Program pursuant to this~~
17 ~~subsection so long as that person continues to meet the~~
18 ~~eligibility criteria established under the emergency rule at 89~~
19 ~~Ill. Adm. Code 120 (Illinois Register Volume 31, page 15854)~~
20 ~~filed November 7, 2007. In no case may a person continue to be~~
21 ~~enrolled in the FamilyCare Program pursuant to this subsection~~
22 ~~if the person's income rises above 400% of the Federal Poverty~~
23 ~~Level or falls below 185% of the Federal Poverty Level at any~~
24 ~~subsequent time. Nothing contained in this subsection shall~~
25 ~~prevent an individual from enrolling in the FamilyCare Program~~
26 ~~as authorized by paragraph 15 of Section 5-2 of this Code if he~~

1 ~~or she otherwise qualifies under that Section.~~

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

13 (Source: P.A. 96-20, eff. 6-30-09.)

14 (305 ILCS 5/12-4.39)

15 Sec. 12-4.39. Dental clinic grant program.

16 (a) Grant program. On and after July 1, 2012, and subject
17 ~~Subject~~ to funding availability, the Department of Healthcare
18 and Family Services may ~~shall~~ administer a grant program. The
19 purpose of this grant program shall be to build the public
20 infrastructure for dental care and to make grants to local
21 health departments, federally qualified health clinics
22 (FQHCs), and rural health clinics (RHCs) for development of
23 comprehensive dental clinics for dental care services. The
24 primary purpose of these new dental clinics will be to increase
25 dental access for low-income and Department of Healthcare and

1 Family Services clients who have no dental arrangements with a
2 dental provider in a project's service area. The dental clinic
3 must be willing to accept out-of-area clients who need dental
4 services, including emergency services for adults and Early and
5 Periodic Screening, Diagnosis and Treatment (EPSDT)-referral
6 children. Medically Underserved Areas (MUAs) and Health
7 Professional Shortage Areas (HPSAs) shall receive special
8 priority for grants under this program.

9 (b) Eligible applicants. The following entities are
10 eligible to apply for grants:

11 (1) Local health departments.

12 (2) Federally Qualified Health Centers (FQHCs).

13 (3) Rural health clinics (RHCs).

14 (c) Use of grant moneys. Grant moneys must be used to
15 support projects that develop dental services to meet the
16 dental health care needs of Department of Healthcare and Family
17 Services Dental Program clients. Grant moneys must be used for
18 operating expenses, including, but not limited to: insurance;
19 dental supplies and equipment; dental support services; and
20 renovation expenses. Grant moneys may not be used to offset
21 existing indebtedness, supplant existing funds, purchase real
22 property, or pay for personnel service salaries for dental
23 employees.

24 (d) Application process. The Department shall establish
25 procedures for applying for dental clinic grants.

26 (Source: P.A. 96-67, eff. 7-23-09; 96-1000, eff. 7-2-10.)

1 (305 ILCS 5/12-10.5)

2 Sec. 12-10.5. Medical Special Purposes Trust Fund.

3 (a) The Medical Special Purposes Trust Fund ("the Fund") is
4 created. Any grant, gift, donation, or legacy of money or
5 securities that the Department of Healthcare and Family
6 Services is authorized to receive under Section 12-4.18 or
7 Section 12-4.19 or any monies from any other source, and that
8 are ~~is~~ dedicated for functions connected with the
9 administration of any medical program administered by the
10 Department, shall be deposited into the Fund. All federal
11 moneys received by the Department as reimbursement for
12 disbursements authorized to be made from the Fund shall also be
13 deposited into the Fund. In addition, federal moneys received
14 on account of State expenditures made in connection with
15 obtaining compliance with the federal Health Insurance
16 Portability and Accountability Act (HIPAA) shall be deposited
17 into the Fund.

18 (b) No moneys received from a service provider or a
19 governmental or private entity that is enrolled with the
20 Department as a provider of medical services shall be deposited
21 into the Fund.

22 (c) Disbursements may be made from the Fund for the
23 purposes connected with the grants, gifts, donations, ~~or~~
24 legacies, or other monies deposited into the Fund, including,
25 but not limited to, medical quality assessment projects,

1 eligibility population studies, medical information systems
2 evaluations, and other administrative functions that assist
3 the Department in fulfilling its health care mission under any
4 medical program administered by the Department.

5 (Source: P.A. 97-48, eff. 6-28-11.)

6 (305 ILCS 5/12-13.1)

7 Sec. 12-13.1. Inspector General.

8 (a) The Governor shall appoint, and the Senate shall
9 confirm, an Inspector General who shall function within the
10 Illinois Department of Public Aid (now Healthcare and Family
11 Services) and report to the Governor. The term of the Inspector
12 General shall expire on the third Monday of January, 1997 and
13 every 4 years thereafter.

14 (b) In order to prevent, detect, and eliminate fraud,
15 waste, abuse, mismanagement, and misconduct, the Inspector
16 General shall oversee the Department of Healthcare and Family
17 Services' integrity functions, which include, but are not
18 limited to, the following:

19 (1) Investigation of misconduct by employees, vendors,
20 contractors and medical providers, except for allegations
21 of violations of the State Officials and Employees Ethics
22 Act which shall be referred to the Office of the Governor's
23 Executive Inspector General for investigation.

24 (2) Prepayment and post-payment audits ~~Audits~~ of
25 medical providers related to ensuring that appropriate

1 payments are made for services rendered and to the
2 prevention and recovery of overpayments.

3 (3) Monitoring of quality assurance programs
4 administered by the Department of Healthcare and Family
5 Services ~~generally related to the medical assistance~~
6 ~~program and specifically related to any managed care~~
7 ~~program.~~

8 (4) Quality control measurements of the programs
9 administered by the Department of Healthcare and Family
10 Services.

11 (5) Investigations of fraud or intentional program
12 violations committed by clients of the Department of
13 Healthcare and Family Services.

14 (6) Actions initiated against contractors, vendors, or
15 medical providers for any of the following reasons:

16 (A) Violations of the medical assistance program.

17 (B) Sanctions against providers brought in
18 conjunction with the Department of Public Health or the
19 Department of Human Services (as successor to the
20 Department of Mental Health and Developmental
21 Disabilities).

22 (C) Recoveries of assessments against hospitals
23 and long-term care facilities.

24 (D) Sanctions mandated by the United States
25 Department of Health and Human Services against
26 medical providers.

1 (E) Violations of contracts related to any
2 programs administered by the Department of Healthcare
3 and Family Services ~~managed care programs.~~

4 (7) Representation of the Department of Healthcare and
5 Family Services at hearings with the Illinois Department of
6 Financial and Professional Regulation in actions taken
7 against professional licenses held by persons who are in
8 violation of orders for child support payments.

9 (b-5) At the request of the Secretary of Human Services,
10 the Inspector General shall, in relation to any function
11 performed by the Department of Human Services as successor to
12 the Department of Public Aid, exercise one or more of the
13 powers provided under this Section as if those powers related
14 to the Department of Human Services; in such matters, the
15 Inspector General shall report his or her findings to the
16 Secretary of Human Services.

17 (c) Notwithstanding, and in addition to, any other
18 provision of law, the ~~The~~ Inspector General shall have access
19 to all information, personnel and facilities of the Department
20 of Healthcare and Family Services and the Department of Human
21 Services (as successor to the Department of Public Aid), their
22 employees, vendors, contractors and medical providers and any
23 federal, State or local governmental agency that are necessary
24 to perform the duties of the Office as directly related to
25 public assistance programs administered by those departments.
26 No medical provider shall be compelled, however, to provide

1 individual medical records of patients who are not clients of
2 the programs administered by the Department of Healthcare and
3 Family Services ~~Medical Assistance Program~~. State and local
4 governmental agencies are authorized and directed to provide
5 the requested information, assistance or cooperation.

6 For purposes of enhanced program integrity functions and
7 oversight, and to the extent consistent with applicable
8 information and privacy, security, and disclosure laws, State
9 agencies and departments shall provide the Office of Inspector
10 General access to confidential and other information and data,
11 and the Inspector General is authorized to enter into
12 agreements with appropriate federal agencies and departments
13 to secure similar data. This includes, but is not limited to,
14 information pertaining to: licensure; certification; earnings;
15 immigration status; citizenship; wage reporting; unearned and
16 earned income; pension income; employment; supplemental
17 security income; social security numbers; National Provider
18 Identifier (NPI) numbers; the National Practitioner Data Bank
19 (NPDB); program and agency exclusions; taxpayer identification
20 numbers; tax delinquency; corporate information; and death
21 records.

22 The Inspector General shall enter into agreements with
23 State agencies and departments, and is authorized to enter into
24 agreements with federal agencies and departments, under which
25 such agencies and departments shall share data necessary for
26 medical assistance program integrity functions and oversight.

1 The Inspector General shall enter into agreements with State
2 agencies and departments, and is authorized to enter into
3 agreements with federal agencies and departments, under which
4 such agencies shall share data necessary for recipient and
5 vendor screening, review, and investigation, including but not
6 limited to vendor payment and recipient eligibility
7 verification. The Inspector General shall develop, in
8 cooperation with other State and federal agencies and
9 departments, and in compliance with applicable federal laws and
10 regulations, appropriate and effective methods to share such
11 data. The Inspector General shall enter into agreements with
12 State agencies and departments, and is authorized to enter into
13 agreements with federal agencies and departments, including,
14 but not limited to: the Secretary of State; the Department of
15 Revenue; the Department of Public Health; the Department of
16 Human Services; and the Department of Financial and
17 Professional Regulation.

18 The Inspector General shall have the authority to deny
19 payment, prevent overpayments, and recover overpayments.

20 The Inspector General shall have the authority to deny or
21 suspend payment to, and deny, terminate, or suspend the
22 eligibility of, any vendor who fails to grant the Inspector
23 General timely access to full and complete records, including
24 records of recipients under the medical assistance program for
25 the most recent 6 years, in accordance with Section 140.28 of
26 Title 89 of the Illinois Administrative Code, and other

1 information for the purpose of audits, investigations, or other
2 program integrity functions, after reasonable written request
3 by the Inspector General.

4 (d) The Inspector General shall serve as the Department of
5 Healthcare and Family Services' primary liaison with law
6 enforcement, investigatory and prosecutorial agencies,
7 including but not limited to the following:

8 (1) The Department of State Police.

9 (2) The Federal Bureau of Investigation and other
10 federal law enforcement agencies.

11 (3) The various Inspectors General of federal agencies
12 overseeing the programs administered by the Department of
13 Healthcare and Family Services.

14 (4) The various Inspectors General of any other State
15 agencies with responsibilities for portions of programs
16 primarily administered by the Department of Healthcare and
17 Family Services.

18 (5) The Offices of the several United States Attorneys
19 in Illinois.

20 (6) The several State's Attorneys.

21 (7) The offices of the Centers for Medicare and
22 Medicaid Services that administer the Medicare and
23 Medicaid integrity programs.

24 The Inspector General shall meet on a regular basis with
25 these entities to share information regarding possible
26 misconduct by any persons or entities involved with the public

1 aid programs administered by the Department of Healthcare and
2 Family Services.

3 (e) All investigations conducted by the Inspector General
4 shall be conducted in a manner that ensures the preservation of
5 evidence for use in criminal prosecutions. If the Inspector
6 General determines that a possible criminal act relating to
7 fraud in the provision or administration of the medical
8 assistance program has been committed, the Inspector General
9 shall immediately notify the Medicaid Fraud Control Unit. If
10 the Inspector General determines that a possible criminal act
11 has been committed within the jurisdiction of the Office, the
12 Inspector General may request the special expertise of the
13 Department of State Police. The Inspector General may present
14 for prosecution the findings of any criminal investigation to
15 the Office of the Attorney General, the Offices of the several
16 United States Attorneys in Illinois or the several State's
17 Attorneys.

18 (f) To carry out his or her duties as described in this
19 Section, the Inspector General and his or her designees shall
20 have the power to compel by subpoena the attendance and
21 testimony of witnesses and the production of books, electronic
22 records and papers as directly related to public assistance
23 programs administered by the Department of Healthcare and
24 Family Services or the Department of Human Services (as
25 successor to the Department of Public Aid). No medical provider
26 shall be compelled, however, to provide individual medical

1 records of patients who are not clients of the Medical
2 Assistance Program.

3 (g) The Inspector General shall report all convictions,
4 terminations, and suspensions taken against vendors,
5 contractors and medical providers to the Department of
6 Healthcare and Family Services and to any agency responsible
7 for licensing or regulating those persons or entities.

8 (h) The Inspector General shall make annual reports,
9 findings, and recommendations regarding the Office's
10 investigations into reports of fraud, waste, abuse,
11 mismanagement, or misconduct relating to any ~~public-aid~~
12 programs administered by the Department of Healthcare and
13 Family Services or the Department of Human Services (as
14 successor to the Department of Public Aid) to the General
15 Assembly and the Governor. These reports shall include, but not
16 be limited to, the following information:

17 (1) Aggregate provider billing and payment
18 information, including the number of providers at various
19 Medicaid earning levels.

20 (2) The number of audits of the medical assistance
21 program and the dollar savings resulting from those audits.

22 (3) The number of prescriptions rejected annually
23 under the Department of Healthcare and Family Services'
24 Refill Too Soon program and the dollar savings resulting
25 from that program.

26 (4) Provider sanctions, in the aggregate, including

1 terminations and suspensions.

2 (5) A detailed summary of the investigations
3 undertaken in the previous fiscal year. These summaries
4 shall comply with all laws and rules regarding maintaining
5 confidentiality in the public aid programs.

6 (i) Nothing in this Section shall limit investigations by
7 the Department of Healthcare and Family Services or the
8 Department of Human Services that may otherwise be required by
9 law or that may be necessary in their capacity as the central
10 administrative authorities responsible for administration of
11 their agency's ~~public aid~~ programs in this State.

12 (j) The Inspector General may issue shields or other
13 distinctive identification to his or her employees not
14 exercising the powers of a peace officer if the Inspector
15 General determines that a shield or distinctive identification
16 is needed by an employee to carry out his or her
17 responsibilities.

18 (Source: P.A. 95-331, eff. 8-21-07; 96-555, eff. 8-18-09;
19 96-1316, eff. 1-1-11.)

20 (305 ILCS 5/14-8) (from Ch. 23, par. 14-8)

21 Sec. 14-8. Disbursements to Hospitals.

22 (a) For inpatient hospital services rendered on and after
23 September 1, 1991, the Illinois Department shall reimburse
24 hospitals for inpatient services at an inpatient payment rate
25 calculated for each hospital based upon the Medicare

1 Prospective Payment System as set forth in Sections 1886(b),
2 (d), (g), and (h) of the federal Social Security Act, and the
3 regulations, policies, and procedures promulgated thereunder,
4 except as modified by this Section. Payment rates for inpatient
5 hospital services rendered on or after September 1, 1991 and on
6 or before September 30, 1992 shall be calculated using the
7 Medicare Prospective Payment rates in effect on September 1,
8 1991. Payment rates for inpatient hospital services rendered on
9 or after October 1, 1992 and on or before March 31, 1994 shall
10 be calculated using the Medicare Prospective Payment rates in
11 effect on September 1, 1992. Payment rates for inpatient
12 hospital services rendered on or after April 1, 1994 shall be
13 calculated using the Medicare Prospective Payment rates
14 (including the Medicare grouping methodology and weighting
15 factors as adjusted pursuant to paragraph (1) of this
16 subsection) in effect 90 days prior to the date of admission.
17 For services rendered on or after July 1, 1995, the
18 reimbursement methodology implemented under this subsection
19 shall not include those costs referred to in Sections
20 1886(d)(5)(B) and 1886(h) of the Social Security Act. The
21 additional payment amounts required under Section
22 1886(d)(5)(F) of the Social Security Act, for hospitals serving
23 a disproportionate share of low-income or indigent patients,
24 are not required under this Section. For hospital inpatient
25 services rendered on or after July 1, 1995, the Illinois
26 Department shall reimburse hospitals using the relative

1 weighting factors and the base payment rates calculated for
2 each hospital that were in effect on June 30, 1995, less the
3 portion of such rates attributed by the Illinois Department to
4 the cost of medical education.

5 (1) The weighting factors established under Section
6 1886(d)(4) of the Social Security Act shall not be used in
7 the reimbursement system established under this Section.
8 Rather, the Illinois Department shall establish by rule
9 Medicaid weighting factors to be used in the reimbursement
10 system established under this Section.

11 (2) The Illinois Department shall define by rule those
12 hospitals or distinct parts of hospitals that shall be
13 exempt from the reimbursement system established under
14 this Section. In defining such hospitals, the Illinois
15 Department shall take into consideration those hospitals
16 exempt from the Medicare Prospective Payment System as of
17 September 1, 1991. For hospitals defined as exempt under
18 this subsection, the Illinois Department shall by rule
19 establish a reimbursement system for payment of inpatient
20 hospital services rendered on and after September 1, 1991.
21 For all hospitals that are children's hospitals as defined
22 in Section 5-5.02 of this Code, the reimbursement
23 methodology shall, through June 30, 1992, net of all
24 applicable fees, at least equal each children's hospital
25 1990 ICARE payment rates, indexed to the current year by
26 application of the DRI hospital cost index from 1989 to the

1 year in which payments are made. Excepting county providers
2 as defined in Article XV of this Code, hospitals licensed
3 under the University of Illinois Hospital Act, and
4 facilities operated by the Department of Mental Health and
5 Developmental Disabilities (or its successor, the
6 Department of Human Services) for hospital inpatient
7 services rendered on or after July 1, 1995, the Illinois
8 Department shall reimburse children's hospitals, as
9 defined in 89 Illinois Administrative Code Section
10 149.50(c)(3), at the rates in effect on June 30, 1995, and
11 shall reimburse all other hospitals at the rates in effect
12 on June 30, 1995, less the portion of such rates attributed
13 by the Illinois Department to the cost of medical
14 education. For inpatient hospital services provided on or
15 after August 1, 1998, the Illinois Department may establish
16 by rule a means of adjusting the rates of children's
17 hospitals, as defined in 89 Illinois Administrative Code
18 Section 149.50(c)(3), that did not meet that definition on
19 June 30, 1995, in order for the inpatient hospital rates of
20 such hospitals to take into account the average inpatient
21 hospital rates of those children's hospitals that did meet
22 the definition of children's hospitals on June 30, 1995.

23 (3) (Blank)

24 (4) Notwithstanding any other provision of this
25 Section, hospitals that on August 31, 1991, have a contract
26 with the Illinois Department under Section 3-4 of the

1 Illinois Health Finance Reform Act may elect to continue to
2 be reimbursed at rates stated in such contracts for general
3 and specialty care.

4 (5) In addition to any payments made under this
5 subsection (a), the Illinois Department shall make the
6 adjustment payments required by Section 5-5.02 of this
7 Code; provided, that in the case of any hospital reimbursed
8 under a per case methodology, the Illinois Department shall
9 add an amount equal to the product of the hospital's
10 average length of stay, less one day, multiplied by 20, for
11 inpatient hospital services rendered on or after September
12 1, 1991 and on or before September 30, 1992.

13 (b) (Blank)

14 (b-5) Excepting county providers as defined in Article XV
15 of this Code, hospitals licensed under the University of
16 Illinois Hospital Act, and facilities operated by the Illinois
17 Department of Mental Health and Developmental Disabilities (or
18 its successor, the Department of Human Services), for
19 outpatient services rendered on or after July 1, 1995 and
20 before July 1, 1998 the Illinois Department shall reimburse
21 children's hospitals, as defined in the Illinois
22 Administrative Code Section 149.50(c)(3), at the rates in
23 effect on June 30, 1995, less that portion of such rates
24 attributed by the Illinois Department to the outpatient
25 indigent volume adjustment and shall reimburse all other
26 hospitals at the rates in effect on June 30, 1995, less the

1 portions of such rates attributed by the Illinois Department to
2 the cost of medical education and attributed by the Illinois
3 Department to the outpatient indigent volume adjustment. For
4 outpatient services provided on or after July 1, 1998,
5 reimbursement rates shall be established by rule.

6 (c) In addition to any other payments under this Code, the
7 Illinois Department shall develop a hospital disproportionate
8 share reimbursement methodology that, effective July 1, 1991,
9 through September 30, 1992, shall reimburse hospitals
10 sufficiently to expend the fee monies described in subsection
11 (b) of Section 14-3 of this Code and the federal matching funds
12 received by the Illinois Department as a result of expenditures
13 made by the Illinois Department as required by this subsection
14 (c) and Section 14-2 that are attributable to fee monies
15 deposited in the Fund, less amounts applied to adjustment
16 payments under Section 5-5.02.

17 (d) Critical Care Access Payments.

18 (1) In addition to any other payments made under this
19 Code, the Illinois Department shall develop a
20 reimbursement methodology that shall reimburse Critical
21 Care Access Hospitals for the specialized services that
22 qualify them as Critical Care Access Hospitals. No
23 adjustment payments shall be made under this subsection on
24 or after July 1, 1995.

25 (2) "Critical Care Access Hospitals" includes, but is
26 not limited to, hospitals that meet at least one of the

1 following criteria:

2 (A) Hospitals located outside of a metropolitan
3 statistical area that are designated as Level II
4 Perinatal Centers and that provide a disproportionate
5 share of perinatal services to recipients; or

6 (B) Hospitals that are designated as Level I Trauma
7 Centers (adult or pediatric) and certain Level II
8 Trauma Centers as determined by the Illinois
9 Department; or

10 (C) Hospitals located outside of a metropolitan
11 statistical area and that provide a disproportionate
12 share of obstetrical services to recipients.

13 (e) Inpatient high volume adjustment. For hospital
14 inpatient services, effective with rate periods beginning on or
15 after October 1, 1993, in addition to rates paid for inpatient
16 services by the Illinois Department, the Illinois Department
17 shall make adjustment payments for inpatient services
18 furnished by Medicaid high volume hospitals. The Illinois
19 Department shall establish by rule criteria for qualifying as a
20 Medicaid high volume hospital and shall establish by rule a
21 reimbursement methodology for calculating these adjustment
22 payments to Medicaid high volume hospitals. No adjustment
23 payment shall be made under this subsection for services
24 rendered on or after July 1, 1995.

25 (f) The Illinois Department shall modify its current rules
26 governing adjustment payments for targeted access, critical

1 care access, and uncompensated care to classify those
2 adjustment payments as not being payments to disproportionate
3 share hospitals under Title XIX of the federal Social Security
4 Act. Rules adopted under this subsection shall not be effective
5 with respect to services rendered on or after July 1, 1995. The
6 Illinois Department has no obligation to adopt or implement any
7 rules or make any payments under this subsection for services
8 rendered on or after July 1, 1995.

9 (f-5) The State recognizes that adjustment payments to
10 hospitals providing certain services or incurring certain
11 costs may be necessary to assure that recipients of medical
12 assistance have adequate access to necessary medical services.
13 These adjustments include payments for teaching costs and
14 uncompensated care, trauma center payments, rehabilitation
15 hospital payments, perinatal center payments, obstetrical care
16 payments, targeted access payments, Medicaid high volume
17 payments, and outpatient indigent volume payments. On or before
18 April 1, 1995, the Illinois Department shall issue
19 recommendations regarding (i) reimbursement mechanisms or
20 adjustment payments to reflect these costs and services,
21 including methods by which the payments may be calculated and
22 the method by which the payments may be financed, and (ii)
23 reimbursement mechanisms or adjustment payments to reflect
24 costs and services of federally qualified health centers with
25 respect to recipients of medical assistance.

26 (g) If one or more hospitals file suit in any court

1 challenging any part of this Article XIV, payments to hospitals
2 under this Article XIV shall be made only to the extent that
3 sufficient monies are available in the Fund and only to the
4 extent that any monies in the Fund are not prohibited from
5 disbursement under any order of the court.

6 (h) Payments under the disbursement methodology described
7 in this Section are subject to approval by the federal
8 government in an appropriate State plan amendment.

9 (i) The Illinois Department may by rule establish criteria
10 for and develop methodologies for adjustment payments to
11 hospitals participating under this Article.

12 (j) Hospital Residing Long Term Care Services. In addition
13 to any other payments made under this Code, the Illinois
14 Department may by rule establish criteria and develop
15 methodologies for payments to hospitals for Hospital Residing
16 Long Term Care Services.

17 (k) Critical Access Hospital outpatient payments. In
18 addition to any other payments authorized under this Code, the
19 Illinois Department shall reimburse critical access hospitals,
20 as designated by the Illinois Department of Public Health in
21 accordance with 42 CFR 485, Subpart F, for outpatient services
22 at an amount that is no less than the cost of providing such
23 services, based on Medicare cost principles. Payments under
24 this subsection shall be subject to appropriation.

25 (l) On and after July 1, 2012, the Department shall reduce
26 any rate of reimbursement for services or other payments or

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

4 (Source: P.A. 96-1382, eff. 1-1-11.)

5 (305 ILCS 5/14-11 new)

6 Sec. 14-11. Hospital payment reform.

7 (a) The Department may, by rule, implement the All Patient
8 Refined Diagnosis Related Groups (APR-DRG) payment system for
9 inpatient services provided on or after July 1, 2013, in a
10 manner consistent with the actions authorized in this Section.

11 (b) On or before October 1, 2012 and through June 30, 2013,
12 the Department shall begin testing the APR-DRG system. During
13 the testing period the Department shall process and price
14 inpatient services using the APR-DRG system; however, actual
15 payments for those inpatient services shall be made using the
16 current reimbursement system. During the testing period, the
17 Department, in collaboration with the statewide representative
18 of hospitals, shall provide information and technical
19 assistance to hospitals to encourage and facilitate their
20 transition to the APR-DRG system.

21 (c) The Department may, by rule, implement the Enhanced
22 Ambulatory Procedure Grouping (EAPG) system for outpatient
23 services provided on or after January 1, 2014, in a manner
24 consistent with the actions authorized in this Section. On or
25 before January 1, 2013 and through December 31, 2013, the

1 Department shall begin testing the EAPG system. During the
2 testing period the Department shall process and price
3 outpatient services using the EAPG system; however, actual
4 payments for those outpatient services shall be made using the
5 current reimbursement system. During the testing period, the
6 Department, in collaboration with the statewide representative
7 of hospitals, shall provide information and technical
8 assistance to hospitals to encourage and facilitate their
9 transition to the EAPG system.

10 (d) The Department in consultation with the current
11 hospital technical advisory group shall review the test claims
12 for inpatient and outpatient services at least monthly,
13 including the estimated impact on hospitals, and, in developing
14 the rules, policies, and procedures to implement the new
15 payment systems, shall consider at least the following issues:

16 (1) The use of national relative weights provided by
17 the vendor of the APR-DRG system, adjusted to reflect
18 characteristics of the Illinois Medical Assistance
19 population.

20 (2) An updated outlier payment methodology based on
21 current data and consistent with the APR-DRG system.

22 (3) The use of policy adjusters to enhance payments to
23 hospitals treating a high percentage of individuals
24 covered by the Medical Assistance program and uninsured
25 patients.

26 (4) Reimbursement for inpatient specialty services

1 such as psychiatric, rehabilitation, and long-term acute
2 care using updated per diem rates that account for service
3 acuity.

4 (5) The creation of one or more transition funding
5 pools to preserve access to care and to ensure financial
6 stability as hospitals transition to the new payment
7 system.

8 (6) Whether, beginning July 1, 2014, some of the static
9 adjustment payments financed by General Revenue funds
10 should be used as part of the base payment system,
11 including as policy adjusters to recognize the additional
12 costs of certain services, such as pediatric or neonatal,
13 or providers, such as trauma centers, Critical Access
14 Hospitals, or high Medicaid hospitals, or for services to
15 uninsured patients.

16 (e) The Department shall provide the association
17 representing the majority of hospitals in Illinois, as the
18 statewide representative of the hospital community, with a
19 monthly file of claims adjudicated under the test system for
20 the purpose of review and analysis as part of the collaboration
21 between the State and the hospital community. The file shall
22 consist of a de-identified extract compliant with the Health
23 Insurance Portability and Accountability Act (HIPAA).

24 (f) The current hospital technical advisory group shall
25 make recommendations for changes during the testing period and
26 recommendations for changes prior to the effective dates of the

1 new payment systems. The Department shall draft administrative
2 rules to implement the new payment systems and provide them to
3 the technical advisory group at least 90 days prior to the
4 proposed effective dates of the new payment systems.

5 (g) The payments to hospitals financed by the current
6 hospital assessment, authorized under Article V-A of this Code,
7 are scheduled to sunset on June 30, 2014. The continuation of
8 or revisions to the hospital assessment program shall take into
9 consideration the impact on hospitals and access to care as a
10 result of the changes to the hospital payment system.

11 (h) Beginning July 1, 2014, the Department may transition
12 current General Revenue funded supplemental payments into the
13 claims based system over a period of no less than 2 years from
14 the implementation date of the new payment systems and no more
15 than 4 years from the implementation date of the new payment
16 systems, provided however that the Department may adopt, by
17 rule, supplemental payments to help ensure access to care in a
18 geographic area or to help ensure access to specialty services.
19 For any supplemental payments that are adopted that are based
20 on historic data, the data shall be no older than 3 years and
21 the supplemental payment shall be effective for no longer than
22 2 years before requiring the data to be updated.

23 (i) Any payments authorized under 89 Illinois
24 Administrative Code 148 set to expire in State fiscal year 2012
25 and that were paid out to hospitals in State fiscal year 2012,
26 shall remain in effect as long as the assessment imposed by

1 Section 5A-2 is in effect.

2 (j) Subsections (a) and (c) of this Section shall remain
3 operative unless the Auditor General has reported that: (i) the
4 Department has not undertaken the required actions listed in
5 the report required by subsection (a) of Section 2-20 of the
6 Illinois State Auditing Act; or (ii) the Department has failed
7 to comply with the reporting requirements of Section 2-20 of
8 the Illinois State Auditing Act.

9 (k) Subsections (a) and (c) of this Section shall not be
10 operative until final federal approval by the Centers for
11 Medicare and Medicaid Services of the U.S. Department of Health
12 and Human Services and implementation of all of the payments
13 and assessments in Article V-A in its form as of the effective
14 date of this amendatory Act of the 97th General Assembly or as
15 it may be amended.

16 (305 ILCS 5/15-1) (from Ch. 23, par. 15-1)

17 Sec. 15-1. Definitions. As used in this Article, unless the
18 context requires otherwise:

19 (a) (Blank). ~~"Base amount" means \$108,800,000 multiplied~~
20 ~~by a fraction, the numerator of which is the number of days~~
21 ~~represented by the payments in question and the denominator of~~
22 ~~which is 365.~~

23 (a-5) "County provider" means a health care provider that
24 is, or is operated by, a county with a population greater than
25 3,000,000.

1 (b) "Fund" means the County Provider Trust Fund.

2 (c) "Hospital" or "County hospital" means a hospital, as
3 defined in Section 14-1 of this Code, which is a county
4 hospital located in a county of over 3,000,000 population.

5 (Source: P.A. 87-13; 88-85; 88-554, eff. 7-26-94.)

6 (305 ILCS 5/15-2) (from Ch. 23, par. 15-2)

7 Sec. 15-2. County Provider Trust Fund.

8 (a) There is created in the State Treasury the County
9 Provider Trust Fund. Interest earned by the Fund shall be
10 credited to the Fund. The Fund shall not be used to replace any
11 funds appropriated to the Medicaid program by the General
12 Assembly.

13 (b) The Fund is created solely for the purposes of
14 receiving, investing, and distributing monies in accordance
15 with this Article XV. The Fund shall consist of:

16 (1) All monies collected or received by the Illinois
17 Department under Section 15-3 of this Code;

18 (2) All federal financial participation monies
19 received by the Illinois Department pursuant to Title XIX
20 of the Social Security Act, 42 U.S.C. 1396b, attributable
21 to eligible expenditures made by the Illinois Department
22 pursuant to Section 15-5 of this Code;

23 (3) All federal moneys received by the Illinois
24 Department pursuant to Title XXI of the Social Security Act
25 attributable to eligible expenditures made by the Illinois

1 Department pursuant to Section 15-5 of this Code; and

2 (4) All other monies received by the Fund from any
3 source, including interest thereon.

4 (c) Disbursements from the Fund shall be by warrants drawn
5 by the State Comptroller upon receipt of vouchers duly executed
6 and certified by the Illinois Department and shall be made
7 only:

8 (1) For hospital inpatient care, hospital outpatient
9 care, care provided by other outpatient facilities
10 operated by a county, and disproportionate share hospital
11 adjustment payments made under Title XIX of the Social
12 Security Act and Article V of this Code as required by
13 Section 15-5 of this Code;

14 (1.5) For services provided or purchased by county
15 providers pursuant to Section 5-11 of this Code;

16 (2) For the reimbursement of administrative expenses
17 incurred by county providers on behalf of the Illinois
18 Department as permitted by Section 15-4 of this Code;

19 (3) For the reimbursement of monies received by the
20 Fund through error or mistake;

21 (4) For the payment of administrative expenses
22 necessarily incurred by the Illinois Department or its
23 agent in performing the activities required by this Article
24 XV;

25 (5) For the payment of any amounts that are
26 reimbursable to the federal government, attributable

1 solely to the Fund, and required to be paid by State
2 warrant; ~~and~~

3 (6) For hospital inpatient care, hospital outpatient
4 care, care provided by other outpatient facilities
5 operated by a county, and disproportionate share hospital
6 adjustment payments made under Title XXI of the Social
7 Security Act, pursuant to Section 15-5 of this Code; and -

8 (7) For medical care and related services provided
9 pursuant to a contract with a county.

10 (Source: P.A. 95-859, eff. 8-19-08.)

11 (305 ILCS 5/15-5) (from Ch. 23, par. 15-5)
12 Sec. 15-5. Disbursements from the Fund.

13 (a) The monies in the Fund shall be disbursed only as
14 provided in Section 15-2 of this Code and as follows:

15 (1) To the extent that such costs are reimbursable
16 under federal law, to pay the county hospitals' inpatient
17 reimbursement rates based on actual costs incurred,
18 trended forward annually by an inflation index.

19 (2) To the extent that such costs are reimbursable
20 under federal law, to pay county hospitals and county
21 operated outpatient facilities for outpatient services
22 based on a federally approved methodology to cover the
23 maximum allowable costs.

24 (3) To pay the county hospitals disproportionate share
25 hospital adjustment payments as may be specified in the

1 Illinois Title XIX State plan.

2 (3.5) To pay county providers for services provided or
3 purchased pursuant to Section 5-11 of this Code.

4 (4) To reimburse the county providers for expenses
5 contractually assumed pursuant to Section 15-4 of this
6 Code.

7 (5) To pay the Illinois Department its necessary
8 administrative expenses relative to the Fund and other
9 amounts agreed to, if any, by the county providers in the
10 agreement provided for in subsection (c).

11 (6) To pay the county providers any other amount due
12 according to a federally approved State plan, including but
13 not limited to payments made under the provisions of
14 Section 701(d)(3)(B) of the federal Medicare, Medicaid,
15 and SCHIP Benefits Improvement and Protection Act of 2000.
16 Intergovernmental transfers supporting payments under this
17 paragraph (6) shall not be subject to the computation
18 described in subsection (a) of Section 15-3 of this Code,
19 but shall be computed as the difference between the total
20 of such payments made by the Illinois Department to county
21 providers less any amount of federal financial
22 participation due the Illinois Department under Titles XIX
23 and XXI of the Social Security Act as a result of such
24 payments to county providers.

25 (b) The Illinois Department shall promptly seek all
26 appropriate amendments to the Illinois Title XIX State Plan to

1 maximize reimbursement, including disproportionate share
2 hospital adjustment payments, to the county providers.

3 (c) (Blank).

4 (d) The payments provided for herein are intended to cover
5 services rendered on and after July 1, 1991, and any agreement
6 executed between a qualifying county and the Illinois
7 Department pursuant to this Section may relate back to that
8 date, provided the Illinois Department obtains federal
9 approval. Any changes in payment rates resulting from the
10 provisions of Article 3 of this amendatory Act of 1992 are
11 intended to apply to services rendered on or after October 1,
12 1992, and any agreement executed between a qualifying county
13 and the Illinois Department pursuant to this Section may be
14 effective as of that date.

15 (e) If one or more hospitals file suit in any court
16 challenging any part of this Article XV, payments to hospitals
17 from the Fund under this Article XV shall be made only to the
18 extent that sufficient monies are available in the Fund and
19 only to the extent that any monies in the Fund are not
20 prohibited from disbursement and may be disbursed under any
21 order of the court.

22 (f) All payments under this Section are contingent upon
23 federal approval of changes to the Title XIX State plan, if
24 that approval is required.

25 (Source: P.A. 95-859, eff. 8-19-08.)

1 (305 ILCS 5/15-11)

2 Sec. 15-11. Uses of State funds.

3 (a) At any point, if State revenues referenced in
4 subsection (b) or (c) of Section 15-10 or additional State
5 grants are disbursed to the Cook County Health and Hospitals
6 System, all funds may be used only for the following:

7 (1) medical services provided at hospitals or clinics
8 owned and operated by the Cook County Health and Hospitals
9 System Bureau of Health Services; ~~or~~

10 (2) information technology to enhance billing
11 capabilities for medical claiming and reimbursement; ~~or~~

12 (3) services purchased by county providers pursuant to
13 Section 5-11 of this Code.

14 (b) State funds may not be used for the following:

15 (1) non-clinical services, except services that may be
16 required by accreditation bodies or State or federal
17 regulatory or licensing authorities;

18 (2) non-clinical support staff, except as pursuant to
19 paragraph (1) of this subsection; or

20 (3) capital improvements, other than investments in
21 medical technology, except for capital improvements that
22 may be required by accreditation bodies or State or federal
23 regulatory or licensing authorities.

24 (Source: P.A. 95-859, eff. 8-19-08.)

25 Section 85. The Pediatric Palliative Care Act is amended by

1 adding Section 3 as follows:

2 (305 ILCS 60/3 new)

3 Sec. 3. Act inoperative. Notwithstanding any other
4 provision of law, this Act is inoperative on and after July 1,
5 2012.

6 (305 ILCS 5/5-5.4a rep.)

7 (305 ILCS 5/5-5.4c rep.)

8 (305 ILCS 5/12-4.36 rep.)

9 Section 88. The Illinois Public Aid Code is amended by
10 repealing Sections 5-5.4a, 5-5.4c, and 12-4.36.

11 Section 90. The Senior Citizens and Disabled Persons
12 Property Tax Relief and Pharmaceutical Assistance Act is
13 amended by changing the title of the Act and Sections 1, 1.5,
14 2, 3.05a, 3.10, 4, 4.05, 5, 6, 7, 8, 9, 12, and 13 as follows:

15 (320 ILCS 25/Act title)

16 An Act in relation to the payment of grants to enable the
17 elderly and the disabled to acquire or retain private housing
18 ~~and to acquire prescription drugs.~~

19 (320 ILCS 25/1) (from Ch. 67 1/2, par. 401)

20 Sec. 1. Short title; common name. This Article shall be
21 known and may be cited as the Senior Citizens and Disabled

1 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.
2 Common references to the "Circuit Breaker Act" mean this
3 Article. As used in this Article, "this Act" means this
4 Article.

5 (Source: P.A. 96-804, eff. 1-1-10.)

6 (320 ILCS 25/1.5)

7 Sec. 1.5. Implementation of Executive Order No. 3 of 2004;
8 termination of the Illinois Senior Citizens and Disabled
9 Persons Pharmaceutical Assistance Program. Executive Order No.
10 3 of 2004, in part, provided for the transfer of the programs
11 under this Act from the Department of Revenue to the Department
12 on Aging and the Department of Healthcare and Family Services.
13 It is the purpose of this amendatory Act of the 96th General
14 Assembly to conform this Act and certain related provisions of
15 other statutes to that Executive Order. This amendatory Act of
16 the 96th General Assembly also makes other substantive changes
17 to this Act.

18 It is the purpose of this amendatory Act of the 97th
19 General Assembly to terminate the Illinois Senior Citizens and
20 Disabled Persons Pharmaceutical Assistance Program on July 1,
21 2012.

22 (Source: P.A. 96-804, eff. 1-1-10.)

23 (320 ILCS 25/2) (from Ch. 67 1/2, par. 402)

24 Sec. 2. Purpose. The purpose of this Act is to provide

1 incentives to the senior citizens and disabled persons of this
2 State to acquire and retain private housing of their choice and
3 at the same time to relieve those citizens from the burdens of
4 extraordinary property taxes ~~and rising drug costs~~ against
5 their increasingly restricted earning power, and thereby to
6 reduce the requirements for public housing in this State.

7 (Source: P.A. 96-804, eff. 1-1-10.)

8 (320 ILCS 25/3.05a)

9 Sec. 3.05a. Additional resident. "Additional resident"
10 means a person who (i) is living in the same residence with a
11 claimant for the claim year and at the time of filing the
12 claim, (ii) is not the spouse of the claimant, (iii) does not
13 file a separate claim under this Act for the same period, and
14 (iv) receives more than half of his or her total financial
15 support for that claim year from the household. Prior to July
16 1, 2012, an ~~An~~ additional resident who meets qualifications may
17 receive pharmaceutical assistance based on a claimant's
18 application.

19 (Source: P.A. 96-804, eff. 1-1-10.)

20 (320 ILCS 25/3.10) (from Ch. 67 1/2, par. 403.10)

21 Sec. 3.10. Regulations. "Regulations" includes both rules
22 promulgated and forms prescribed by the applicable Department.
23 In this Act, references to the rules of the Department on Aging
24 or the Department of Healthcare and Family Services, in effect

1 prior to July 1, 2012, shall be deemed to include, in
2 appropriate cases, the corresponding rules adopted by the
3 Department of Revenue, to the extent that those rules continue
4 in force under Executive Order No. 3 of 2004.

5 (Source: P.A. 96-804, eff. 1-1-10.)

6 (320 ILCS 25/4) (from Ch. 67 1/2, par. 404)

7 Sec. 4. Amount of Grant.

8 (a) In general. Any individual 65 years or older or any
9 individual who will become 65 years old during the calendar
10 year in which a claim is filed, and any surviving spouse of
11 such a claimant, who at the time of death received or was
12 entitled to receive a grant pursuant to this Section, which
13 surviving spouse will become 65 years of age within the 24
14 months immediately following the death of such claimant and
15 which surviving spouse but for his or her age is otherwise
16 qualified to receive a grant pursuant to this Section, and any
17 disabled person whose annual household income is less than the
18 income eligibility limitation, as defined in subsection (a-5)
19 and whose household is liable for payment of property taxes
20 accrued or has paid rent constituting property taxes accrued
21 and is domiciled in this State at the time he or she files his
22 or her claim is entitled to claim a grant under this Act. With
23 respect to claims filed by individuals who will become 65 years
24 old during the calendar year in which a claim is filed, the
25 amount of any grant to which that household is entitled shall

1 be an amount equal to 1/12 of the amount to which the claimant
2 would otherwise be entitled as provided in this Section,
3 multiplied by the number of months in which the claimant was 65
4 in the calendar year in which the claim is filed.

5 (a-5) Income eligibility limitation. For purposes of this
6 Section, "income eligibility limitation" means an amount for
7 grant years 2008 and thereafter:

8 (1) less than \$22,218 for a household containing one
9 person;

10 (2) less than \$29,480 for a household containing 2
11 persons; or

12 (3) less than \$36,740 for a household containing 3 or
13 more persons.

14 For 2009 claim year applications submitted during calendar
15 year 2010, a household must have annual household income of
16 less than \$27,610 for a household containing one person; less
17 than \$36,635 for a household containing 2 persons; or less than
18 \$45,657 for a household containing 3 or more persons.

19 The Department on Aging may adopt rules such that on
20 January 1, 2011, and thereafter, the foregoing household income
21 eligibility limits may be changed to reflect the annual cost of
22 living adjustment in Social Security and Supplemental Security
23 Income benefits that are applicable to the year for which those
24 benefits are being reported as income on an application.

25 If a person files as a surviving spouse, then only his or
26 her income shall be counted in determining his or her household

1 income.

2 (b) Limitation. Except as otherwise provided in
3 subsections (a) and (f) of this Section, the maximum amount of
4 grant which a claimant is entitled to claim is the amount by
5 which the property taxes accrued which were paid or payable
6 during the last preceding tax year or rent constituting
7 property taxes accrued upon the claimant's residence for the
8 last preceding taxable year exceeds 3 1/2% of the claimant's
9 household income for that year but in no event is the grant to
10 exceed (i) \$700 less 4.5% of household income for that year for
11 those with a household income of \$14,000 or less or (ii) \$70 if
12 household income for that year is more than \$14,000.

13 (c) Public aid recipients. If household income in one or
14 more months during a year includes cash assistance in excess of
15 \$55 per month from the Department of Healthcare and Family
16 Services or the Department of Human Services (acting as
17 successor to the Department of Public Aid under the Department
18 of Human Services Act) which was determined under regulations
19 of that Department on a measure of need that included an
20 allowance for actual rent or property taxes paid by the
21 recipient of that assistance, the amount of grant to which that
22 household is entitled, except as otherwise provided in
23 subsection (a), shall be the product of (1) the maximum amount
24 computed as specified in subsection (b) of this Section and (2)
25 the ratio of the number of months in which household income did
26 not include such cash assistance over \$55 to the number twelve.

1 If household income did not include such cash assistance over
2 \$55 for any months during the year, the amount of the grant to
3 which the household is entitled shall be the maximum amount
4 computed as specified in subsection (b) of this Section. For
5 purposes of this paragraph (c), "cash assistance" does not
6 include any amount received under the federal Supplemental
7 Security Income (SSI) program.

8 (d) Joint ownership. If title to the residence is held
9 jointly by the claimant with a person who is not a member of
10 his or her household, the amount of property taxes accrued used
11 in computing the amount of grant to which he or she is entitled
12 shall be the same percentage of property taxes accrued as is
13 the percentage of ownership held by the claimant in the
14 residence.

15 (e) More than one residence. If a claimant has occupied
16 more than one residence in the taxable year, he or she may
17 claim only one residence for any part of a month. In the case
18 of property taxes accrued, he or she shall prorate 1/12 of the
19 total property taxes accrued on his or her residence to each
20 month that he or she owned and occupied that residence; and, in
21 the case of rent constituting property taxes accrued, shall
22 prorate each month's rent payments to the residence actually
23 occupied during that month.

24 (f) (Blank).

25 (g) Effective January 1, 2006, there is hereby established
26 a program of pharmaceutical assistance to the aged and

1 disabled, entitled the Illinois Seniors and Disabled Drug
2 Coverage Program, which shall be administered by the Department
3 of Healthcare and Family Services and the Department on Aging
4 in accordance with this subsection, to consist of coverage of
5 specified prescription drugs on behalf of beneficiaries of the
6 program as set forth in this subsection. Notwithstanding any
7 provisions of this Act to the contrary, on and after July 1,
8 2012, pharmaceutical assistance under this Act shall no longer
9 be provided, and on July 1, 2012 the Illinois Senior Citizens
10 and Disabled Persons Pharmaceutical Assistance Program shall
11 terminate. The following provisions that concern the Illinois
12 Senior Citizens and Disabled Persons Pharmaceutical Assistance
13 Program shall continue to apply on and after July 1, 2012 to
14 the extent necessary to pursue any actions authorized by
15 subsection (d) of Section 9 of this Act with respect to acts
16 which took place prior to July 1, 2012.

17 To become a beneficiary under the program established under
18 this subsection, a person must:

19 (1) be (i) 65 years of age or older or (ii) disabled;

20 and

21 (2) be domiciled in this State; and

22 (3) enroll with a qualified Medicare Part D
23 Prescription Drug Plan if eligible and apply for all
24 available subsidies under Medicare Part D; and

25 (4) for the 2006 and 2007 claim years, have a maximum
26 household income of (i) less than \$21,218 for a household

1 containing one person, (ii) less than \$28,480 for a
2 household containing 2 persons, or (iii) less than \$35,740
3 for a household containing 3 or more persons; and

4 (5) for the 2008 claim year, have a maximum household
5 income of (i) less than \$22,218 for a household containing
6 one person, (ii) \$29,480 for a household containing 2
7 persons, or (iii) \$36,740 for a household containing 3 or
8 more persons; and

9 (6) for 2009 claim year applications submitted during
10 calendar year 2010, have annual household income of less
11 than (i) \$27,610 for a household containing one person;
12 (ii) less than \$36,635 for a household containing 2
13 persons; or (iii) less than \$45,657 for a household
14 containing 3 or more persons; and

15 (7) as of September 1, 2011, have a maximum household
16 income at or below 200% of the federal poverty level.

17 All individuals enrolled as of December 31, 2005, in the
18 pharmaceutical assistance program operated pursuant to
19 subsection (f) of this Section and all individuals enrolled as
20 of December 31, 2005, in the SeniorCare Medicaid waiver program
21 operated pursuant to Section 5-5.12a of the Illinois Public Aid
22 Code shall be automatically enrolled in the program established
23 by this subsection for the first year of operation without the
24 need for further application, except that they must apply for
25 Medicare Part D and the Low Income Subsidy under Medicare Part
26 D. A person enrolled in the pharmaceutical assistance program

1 operated pursuant to subsection (f) of this Section as of
2 December 31, 2005, shall not lose eligibility in future years
3 due only to the fact that they have not reached the age of 65.

4 To the extent permitted by federal law, the Department may
5 act as an authorized representative of a beneficiary in order
6 to enroll the beneficiary in a Medicare Part D Prescription
7 Drug Plan if the beneficiary has failed to choose a plan and,
8 where possible, to enroll beneficiaries in the low-income
9 subsidy program under Medicare Part D or assist them in
10 enrolling in that program.

11 Beneficiaries under the program established under this
12 subsection shall be divided into the following 4 eligibility
13 groups:

14 (A) Eligibility Group 1 shall consist of beneficiaries
15 who are not eligible for Medicare Part D coverage and who
16 are:

17 (i) disabled and under age 65; or

18 (ii) age 65 or older, with incomes over 200% of the
19 Federal Poverty Level; or

20 (iii) age 65 or older, with incomes at or below
21 200% of the Federal Poverty Level and not eligible for
22 federally funded means-tested benefits due to
23 immigration status.

24 (B) Eligibility Group 2 shall consist of beneficiaries
25 who are eligible for Medicare Part D coverage.

26 (C) Eligibility Group 3 shall consist of beneficiaries

1 age 65 or older, with incomes at or below 200% of the
2 Federal Poverty Level, who are not barred from receiving
3 federally funded means-tested benefits due to immigration
4 status and are not eligible for Medicare Part D coverage.

5 If the State applies and receives federal approval for
6 a waiver under Title XIX of the Social Security Act,
7 persons in Eligibility Group 3 shall continue to receive
8 benefits through the approved waiver, and Eligibility
9 Group 3 may be expanded to include disabled persons under
10 age 65 with incomes under 200% of the Federal Poverty Level
11 who are not eligible for Medicare and who are not barred
12 from receiving federally funded means-tested benefits due
13 to immigration status.

14 (D) Eligibility Group 4 shall consist of beneficiaries
15 who are otherwise described in Eligibility Group 2 who have
16 a diagnosis of HIV or AIDS.

17 The program established under this subsection shall cover
18 the cost of covered prescription drugs in excess of the
19 beneficiary cost-sharing amounts set forth in this paragraph
20 that are not covered by Medicare. The Department of Healthcare
21 and Family Services may establish by emergency rule changes in
22 cost-sharing necessary to conform the cost of the program to
23 the amounts appropriated for State fiscal year 2012 and future
24 fiscal years except that the 24-month limitation on the
25 adoption of emergency rules and the provisions of Sections
26 5-115 and 5-125 of the Illinois Administrative Procedure Act

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

5 For purposes of the program established under this
6 subsection, the term "covered prescription drug" has the
7 following meanings:

8 For Eligibility Group 1, "covered prescription drug"
9 means: (1) any cardiovascular agent or drug; (2) any
10 insulin or other prescription drug used in the treatment of
11 diabetes, including syringe and needles used to administer
12 the insulin; (3) any prescription drug used in the
13 treatment of arthritis; (4) any prescription drug used in
14 the treatment of cancer; (5) any prescription drug used in
15 the treatment of Alzheimer's disease; (6) any prescription
16 drug used in the treatment of Parkinson's disease; (7) any
17 prescription drug used in the treatment of glaucoma; (8)
18 any prescription drug used in the treatment of lung disease
19 and smoking-related illnesses; (9) any prescription drug
20 used in the treatment of osteoporosis; and (10) any
21 prescription drug used in the treatment of multiple
22 sclerosis. The Department may add additional therapeutic
23 classes by rule. The Department may adopt a preferred drug
24 list within any of the classes of drugs described in items
25 (1) through (10) of this paragraph. The specific drugs or
26 therapeutic classes of covered prescription drugs shall be

1 indicated by rule.

2 For Eligibility Group 2, "covered prescription drug"
3 means those drugs covered by the Medicare Part D
4 Prescription Drug Plan in which the beneficiary is
5 enrolled.

6 For Eligibility Group 3, "covered prescription drug"
7 means those drugs covered by the Medical Assistance Program
8 under Article V of the Illinois Public Aid Code.

9 For Eligibility Group 4, "covered prescription drug"
10 means those drugs covered by the Medicare Part D
11 Prescription Drug Plan in which the beneficiary is
12 enrolled.

13 Any person otherwise eligible for pharmaceutical
14 assistance under this subsection whose covered drugs are
15 covered by any public program is ineligible for assistance
16 under this subsection to the extent that the cost of those
17 drugs is covered by the other program.

18 The Department of Healthcare and Family Services shall
19 establish by rule the methods by which it will provide for the
20 coverage called for in this subsection. Those methods may
21 include direct reimbursement to pharmacies or the payment of a
22 capitated amount to Medicare Part D Prescription Drug Plans.

23 For a pharmacy to be reimbursed under the program
24 established under this subsection, it must comply with rules
25 adopted by the Department of Healthcare and Family Services
26 regarding coordination of benefits with Medicare Part D

1 Prescription Drug Plans. A pharmacy may not charge a
2 Medicare-enrolled beneficiary of the program established under
3 this subsection more for a covered prescription drug than the
4 appropriate Medicare cost-sharing less any payment from or on
5 behalf of the Department of Healthcare and Family Services.

6 The Department of Healthcare and Family Services or the
7 Department on Aging, as appropriate, may adopt rules regarding
8 applications, counting of income, proof of Medicare status,
9 mandatory generic policies, and pharmacy reimbursement rates
10 and any other rules necessary for the cost-efficient operation
11 of the program established under this subsection.

12 (h) A qualified individual is not entitled to duplicate
13 benefits in a coverage period as a result of the changes made
14 by this amendatory Act of the 96th General Assembly.

15 (Source: P.A. 96-804, eff. 1-1-10; 97-74, eff. 6-30-11; 97-333,
16 eff. 8-12-11.)

17 (320 ILCS 25/4.05)

18 Sec. 4.05. Application.

19 (a) The Department on Aging shall establish the content,
20 required eligibility and identification information, use of
21 social security numbers, and manner of applying for benefits in
22 a simplified format under this Act, ~~including claims filed for~~
23 ~~new or renewed prescription drug benefits.~~

24 (b) An application may be filed on paper or over the
25 Internet ~~to enable persons to apply separately or for both a~~

1 ~~property tax relief grant and pharmaceutical assistance on the~~
2 ~~same application. An application may also enable persons to~~
3 ~~apply for other State or federal programs that provide medical~~
4 ~~or pharmaceutical assistance or other benefits, as determined~~
5 ~~by the Department on Aging in conjunction with the Department~~
6 ~~of Healthcare and Family Services.~~

7 (c) Applications must be filed during the time period
8 prescribed by the Department.

9 (Source: P.A. 96-804, eff. 1-1-10.)

10 (320 ILCS 25/5) (from Ch. 67 1/2, par. 405)

11 Sec. 5. Procedure.

12 (a) In general. Claims must be filed after January 1, on
13 forms prescribed by the Department. No claim may be filed more
14 than one year after December 31 of the year for which the claim
15 is filed. ~~The pharmaceutical assistance identification card~~
16 ~~provided for in subsection (f) of Section 4 shall be valid for~~
17 ~~a period determined by the Department of Healthcare and Family~~
18 ~~Services.~~

19 (b) Claim is Personal. The right to file a claim under this
20 Act shall be personal to the claimant and shall not survive his
21 death, but such right may be exercised on behalf of a claimant
22 by his legal guardian or attorney-in-fact. If a claimant dies
23 after having filed a timely claim, the amount thereof shall be
24 disbursed to his surviving spouse or, if no spouse survives, to
25 his surviving dependent minor children in equal parts, provided

1 the spouse or child, as the case may be, resided with the
2 claimant at the time he filed his claim. If at the time of
3 disbursement neither the claimant nor his spouse is surviving,
4 and no dependent minor children of the claimant are surviving
5 the amount of the claim shall escheat to the State.

6 (c) One claim per household. Only one member of a household
7 may file a claim under this Act in any calendar year; where
8 both members of a household are otherwise entitled to claim a
9 grant under this Act, they must agree as to which of them will
10 file a claim for that year.

11 (d) (Blank).

12 (e) Pharmaceutical Assistance Procedures. Prior to July 1,
13 2012, the ~~The~~ Department of Healthcare and Family Services
14 shall determine eligibility for pharmaceutical assistance
15 using the applicant's current income. The Department shall
16 determine a person's current income in the manner provided by
17 the Department by rule.

18 (f) A person may not under any circumstances charge a fee
19 to a claimant under this Act for assistance in completing an
20 application form for a property tax relief grant ~~or~~
21 ~~pharmaceutical assistance~~ under this Act.

22 (Source: P.A. 96-491, eff. 8-14-09; 96-804, eff. 1-1-10;
23 96-1000, eff. 7-2-10.)

24 (320 ILCS 25/6) (from Ch. 67 1/2, par. 406)

25 Sec. 6. Administration.

1 (a) In general. Upon receipt of a timely filed claim, the
2 Department shall determine whether the claimant is a person
3 entitled to a grant under this Act and the amount of grant to
4 which he is entitled under this Act. The Department may require
5 the claimant to furnish reasonable proof of the statements of
6 domicile, household income, rent paid, property taxes accrued
7 and other matters on which entitlement is based, and may
8 withhold payment of a grant until such additional proof is
9 furnished.

10 (b) Rental determination. If the Department finds that the
11 gross rent used in the computation by a claimant of rent
12 constituting property taxes accrued exceeds the fair rental
13 value for the right to occupy that residence, the Department
14 may determine the fair rental value for that residence and
15 recompute rent constituting property taxes accrued
16 accordingly.

17 (c) Fraudulent claims. The Department shall deny claims
18 which have been fraudulently prepared or when it finds that the
19 claimant has acquired title to his residence or has paid rent
20 for his residence primarily for the purpose of receiving a
21 grant under this Act.

22 (d) (Blank). ~~Pharmaceutical Assistance. The Department~~
23 ~~shall allow all pharmacies licensed under the Pharmacy Practice~~
24 ~~Act to participate as authorized pharmacies unless they have~~
25 ~~been removed from that status for cause pursuant to the terms~~
26 ~~of this Section. The Director of the Department may enter into~~

1 ~~a written contract with any State agency, instrumentality or~~
2 ~~political subdivision, or a fiscal intermediary for the purpose~~
3 ~~of making payments to authorized pharmacies for covered~~
4 ~~prescription drugs and coordinating the program of~~
5 ~~pharmaceutical assistance established by this Act with other~~
6 ~~programs that provide payment for covered prescription drugs.~~
7 ~~Such agreement shall establish procedures for properly~~
8 ~~contracting for pharmacy services, validating reimbursement~~
9 ~~claims, validating compliance of dispensing pharmacists with~~
10 ~~the contracts for participation required under this Section,~~
11 ~~validating the reasonable costs of covered prescription drugs,~~
12 ~~and otherwise providing for the effective administration of~~
13 ~~this Act.~~

14 ~~The Department shall promulgate rules and regulations to~~
15 ~~implement and administer the program of pharmaceutical~~
16 ~~assistance required by this Act, which shall include the~~
17 ~~following:~~

18 ~~(1) Execution of contracts with pharmacies to dispense~~
19 ~~covered prescription drugs. Such contracts shall stipulate~~
20 ~~terms and conditions for authorized pharmacies~~
21 ~~participation and the rights of the State to terminate such~~
22 ~~participation for breach of such contract or for violation~~
23 ~~of this Act or related rules and regulations of the~~
24 ~~Department.~~

25 ~~(2) Establishment of maximum limits on the size of~~
26 ~~prescriptions, new or refilled, which shall be in amounts~~

1 ~~sufficient for 34 days, except as otherwise specified by~~
2 ~~rule for medical or utilization control reasons;~~

3 ~~(3) Establishment of liens upon any and all causes of~~
4 ~~action which accrue to a beneficiary as a result of~~
5 ~~injuries for which covered prescription drugs are directly~~
6 ~~or indirectly required and for which the Director made~~
7 ~~payment or became liable for under this Act;~~

8 ~~(4) Charge or collection of payments from third parties~~
9 ~~or private plans of assistance, or from other programs of~~
10 ~~public assistance for any claim that is properly chargeable~~
11 ~~under the assignment of benefits executed by beneficiaries~~
12 ~~as a requirement of eligibility for the pharmaceutical~~
13 ~~assistance identification card under this Act;~~

14 ~~(4.5) Provision for automatic enrollment of~~
15 ~~beneficiaries into a Medicare Discount Card program~~
16 ~~authorized under the federal Medicare Modernization Act of~~
17 ~~2003 (P.L. 108 391) to coordinate coverage including~~
18 ~~Medicare Transitional Assistance;~~

19 ~~(5) Inspection of appropriate records and audit of~~
20 ~~participating authorized pharmacies to ensure contract~~
21 ~~compliance, and to determine any fraudulent transactions~~
22 ~~or practices under this Act;~~

23 ~~(6) Annual determination of the reasonable costs of~~
24 ~~covered prescription drugs for which payments are made~~
25 ~~under this Act, as provided in Section 3.16 (now repealed);~~

26 ~~(7) Payment to pharmacies under this Act in accordance~~

1 ~~with the State Prompt Payment Act.~~

2 ~~The Department shall annually report to the Governor and~~
3 ~~the General Assembly by March 1st of each year on the~~
4 ~~administration of pharmaceutical assistance under this Act. By~~
5 ~~the effective date of this Act the Department shall determine~~
6 ~~the reasonable costs of covered prescription drugs in~~
7 ~~accordance with Section 3.16 of this Act (now repealed).~~

8 (Source: P.A. 96-328, eff. 8-11-09; 97-333, eff. 8-12-11.)

9 (320 ILCS 25/7) (from Ch. 67 1/2, par. 407)

10 Sec. 7. Payment and denial of claims.

11 (a) In general. The Director shall order the payment from
12 appropriations made for that purpose of grants to claimants
13 under this Act in the amounts to which the Department has
14 determined they are entitled, respectively. If a claim is
15 denied, the Director shall cause written notice of that denial
16 and the reasons for that denial to be sent to the claimant.

17 (b) Payment of claims one dollar and under. Where the
18 amount of the grant computed under Section 4 is less than one
19 dollar, the Department shall pay to the claimant one dollar.

20 (c) Right to appeal. Any person aggrieved by an action or
21 determination of the Department on Aging arising under any of
22 its powers or duties under this Act may request in writing that
23 the Department on Aging reconsider its action or determination,
24 setting out the facts upon which the request is based. The
25 Department on Aging shall consider the request and either

1 modify or affirm its prior action or determination. The
2 Department on Aging may adopt, by rule, procedures for
3 conducting its review under this Section.

4 ~~Any person aggrieved by an action or determination of the~~
5 ~~Department of Healthcare and Family Services arising under any~~
6 ~~of its powers or duties under this Act may request in writing~~
7 ~~that the Department of Healthcare and Family Services~~
8 ~~reconsider its action or determination, setting out the facts~~
9 ~~upon which the request is based. The Department of Healthcare~~
10 ~~and Family Services shall consider the request and either~~
11 ~~modify or affirm its prior action or determination. The~~
12 ~~Department of Healthcare and Family Services may adopt, by~~
13 ~~rule, procedures for conducting its review under this Section.~~

14 (d) (Blank).

15 (Source: P.A. 96-804, eff. 1-1-10.)

16 (320 ILCS 25/8) (from Ch. 67 1/2, par. 408)

17 Sec. 8. Records. Every claimant of a grant under this Act
18 and, prior to July 1, 2012, every applicant for pharmaceutical
19 assistance under this Act shall keep such records, render such
20 statements, file such forms and comply with such rules and
21 regulations as the Department on Aging may from time to time
22 prescribe. The Department on Aging may by regulations require
23 landlords to furnish to tenants statements as to gross rent or
24 rent constituting property taxes accrued.

25 (Source: P.A. 96-804, eff. 1-1-10.)

1 (320 ILCS 25/9) (from Ch. 67 1/2, par. 409)

2 Sec. 9. Fraud; error.

3 (a) Any person who files a fraudulent claim for a grant
4 under this Act, or who for compensation prepares a claim for a
5 grant and knowingly enters false information on an application
6 for any claimant under this Act, or who fraudulently files
7 multiple applications, or who fraudulently states that a
8 nondisabled person is disabled, or who, prior to July 1, 2012,
9 fraudulently procures pharmaceutical assistance benefits, or
10 who fraudulently uses such assistance to procure covered
11 prescription drugs, or who, on behalf of an authorized
12 pharmacy, files a fraudulent request for payment, is guilty of
13 a Class 4 felony for the first offense and is guilty of a Class
14 3 felony for each subsequent offense.

15 (b) (Blank). ~~The Department on Aging and the Department of~~
16 ~~Healthcare and Family Services shall immediately suspend the~~
17 ~~pharmaceutical assistance benefits of any person suspected of~~
18 ~~fraudulent procurement or fraudulent use of such assistance,~~
19 ~~and shall revoke such assistance upon a conviction. A person~~
20 ~~convicted of fraud under subsection (a) shall be permanently~~
21 ~~barred from all of the programs established under this Act.~~

22 (c) The Department on Aging may recover from a claimant any
23 amount paid to that claimant under this Act on account of an
24 erroneous or fraudulent claim, together with 6% interest per
25 year. Amounts recoverable from a claimant by the Department on

1 Aging under this Act may, but need not, be recovered by
2 offsetting the amount owed against any future grant payable to
3 the person under this Act.

4 The Department of Healthcare and Family Services may
5 recover for acts prior to July 1, 2012 from an authorized
6 pharmacy any amount paid to that pharmacy under the
7 pharmaceutical assistance program on account of an erroneous or
8 fraudulent request for payment under that program, together
9 with 6% interest per year. The Department of Healthcare and
10 Family Services may recover from a person who erroneously or
11 fraudulently obtains benefits under the pharmaceutical
12 assistance program the value of the benefits so obtained,
13 together with 6% interest per year.

14 (d) A prosecution for a violation of this Section may be
15 commenced at any time within 3 years of the commission of that
16 violation.

17 (Source: P.A. 96-804, eff. 1-1-10.)

18 (320 ILCS 25/12) (from Ch. 67 1/2, par. 412)

19 Sec. 12. Regulations - Department on Aging.

20 (a) Regulations. Notwithstanding any other provision to
21 the contrary, the Department on Aging may adopt rules regarding
22 applications, proof of eligibility, required identification
23 information, use of social security numbers, counting of
24 income, and a method of computing "gross rent" in the case of a
25 claimant living in a nursing or sheltered care home, and any

1 other rules necessary for the cost-efficient operation of the
2 program established under Section 4.

3 (b) The Department on Aging shall, to the extent of
4 appropriations made for that purpose:

5 (1) attempt to secure the cooperation of appropriate
6 federal, State and local agencies in securing the names and
7 addresses of persons to whom this Act pertains;

8 (2) prepare a mailing list of persons eligible for
9 grants under this Act;

10 (3) secure the cooperation of the Department of
11 Revenue, ~~the Department of Healthcare and Family Services,~~
12 other State agencies, and local business establishments to
13 facilitate distribution of applications under this Act to
14 those eligible to file claims; and

15 (4) through use of direct mail, newspaper
16 advertisements and radio and television advertisements,
17 and all other appropriate means of communication, conduct
18 an on-going public relations program to increase awareness
19 of eligible citizens of the benefits under this Act and the
20 procedures for applying for them.

21 (Source: P.A. 96-804, eff. 1-1-10.)

22 (320 ILCS 25/13) (from Ch. 67 1/2, par. 413)

23 Sec. 13. List of persons who have qualified. The Department
24 on Aging shall maintain a list of all persons who have
25 qualified under this Act and shall make the list available to

1 ~~the Department of Healthcare and Family Services,~~ the
2 Department of Public Health, the Secretary of State,
3 municipalities, and public transit authorities upon request.

4 All information received by a State agency, municipality,
5 or public transit authority under this Section shall be
6 confidential, except for official purposes, and any person who
7 divulges or uses that information in any manner, except in
8 accordance with a proper judicial order, shall be guilty of a
9 Class B misdemeanor.

10 (Source: P.A. 96-804, eff. 1-1-10.)

11 (320 ILCS 25/4.1 rep.)

12 Section 95. The Senior Citizens and Disabled Persons
13 Property Tax Relief and Pharmaceutical Assistance Act is
14 amended by repealing Section 4.1.

15 Section 100. The Sexual Assault Survivors Emergency
16 Treatment Act is amended by changing Section 7 as follows:

17 (410 ILCS 70/7) (from Ch. 111 1/2, par. 87-7)

18 Sec. 7. Reimbursement ~~Charges and reimbursement.~~

19 (a) When any ambulance provider furnishes transportation,
20 hospital provides hospital emergency services and forensic
21 services, hospital or health care professional or laboratory
22 provides follow-up healthcare, or pharmacy dispenses
23 prescribed medications to any sexual assault survivor, as

1 defined by the Department of Healthcare and Family Services,
2 who is neither eligible to receive such services under the
3 Illinois Public Aid Code nor covered as to such services by a
4 policy of insurance, the ambulance provider, hospital, health
5 care professional, pharmacy, or laboratory shall furnish such
6 services to that person without charge and shall be entitled to
7 be reimbursed for ~~its billed charges in~~ providing such services
8 by the Illinois Sexual Assault Emergency Treatment Program
9 under the Department of Healthcare and Family Services.
10 ~~Pharmacies shall dispense prescribed medications without~~
11 ~~charge to the survivor and shall be reimbursed~~ and at the
12 Department of Healthcare and Family Services' ~~Medicaid~~
13 allowable rates under the Illinois Public Aid Code.

14 (b) The hospital is responsible for submitting the request
15 for reimbursement for ambulance services, hospital emergency
16 services, and forensic services to the Illinois Sexual Assault
17 Emergency Treatment Program. Nothing in this Section precludes
18 hospitals from providing follow-up healthcare and receiving
19 reimbursement under this Section.

20 (c) The health care professional who provides follow-up
21 healthcare and the pharmacy that dispenses prescribed
22 medications to a sexual assault survivor are responsible for
23 submitting the request for reimbursement for follow-up
24 healthcare or pharmacy services to the Illinois Sexual Assault
25 Emergency Treatment Program.

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

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

6 (d) The Department of Healthcare and Family Services shall
7 establish standards, rules, and regulations to implement this
8 Section.

9 (Source: P.A. 95-331, eff. 8-21-07; 95-432, eff. 1-1-08.)

10 Section 102. The Hemophilia Care Act is amended by changing
11 Section 3 as follows:

12 (410 ILCS 420/3) (from Ch. 111 1/2, par. 2903)

13 Sec. 3. The powers and duties of the Department shall
14 include the following:

15 (1) With the advice and counsel of the Committee,
16 develop standards for determining eligibility for care and
17 treatment under this program. Among other standards
18 developed under this Section, persons suffering from
19 hemophilia must be evaluated in a center properly staffed
20 and equipped for such evaluation, but not operated by the
21 Department.

22 (2) (Blank).

23 (3) Extend financial assistance to eligible persons in
24 order that they may obtain blood and blood derivatives for

1 use in hospitals, in medical and dental facilities, or at
2 home. The Department shall extend financial assistance in
3 each fiscal year to each family containing one or more
4 eligible persons in the amount of (a) the family's eligible
5 cost of hemophilia services for that fiscal year, minus (b)
6 one fifth of its available family income for its next
7 preceding taxable year. The Director may extend financial
8 assistance in the case of unusual hardships, according to
9 specific procedures and conditions adopted for this
10 purpose in the rules and regulations promulgated by the
11 Department to implement and administer this Act.

12 (4) (Blank).

13 (5) Promulgate rules and regulations with the advice
14 and counsel of the Committee for the implementation and
15 administration of this Act.

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

22 (Source: P.A. 89-507, eff. 7-1-97; 90-587, eff. 7-1-98.)

23 Section 103. The Renal Disease Treatment Act is amended by
24 changing Section 3 as follows:

1 (410 ILCS 430/3) (from Ch. 111 1/2, par. 22.33)

2 Sec. 3. Duties of Departments of Healthcare and Family
3 Services and Public Health.

4 (A) The Department of Healthcare and Family Services shall:

5 (a) With the advice of the Renal Disease Advisory
6 Committee, develop standards for determining eligibility
7 for care and treatment under this program. Among other
8 standards so developed under this paragraph, candidates,
9 to be eligible for care and treatment, must be evaluated in
10 a center properly staffed and equipped for such evaluation.

11 (b) (Blank).

12 (c) (Blank).

13 (d) Extend financial assistance to persons suffering
14 from chronic renal diseases in obtaining the medical,
15 surgical, nursing, pharmaceutical, and technical services
16 necessary in caring for such diseases, including the
17 renting of home dialysis equipment. The Renal Disease
18 Advisory Committee shall recommend to the Department the
19 extent of financial assistance, including the reasonable
20 charges and fees, for:

21 (1) Treatment in a dialysis facility;

22 (2) Hospital treatment for dialysis and transplant
23 surgery;

24 (3) Treatment in a limited care facility;

25 (4) Home dialysis training; and

26 (5) Home dialysis.

1 (e) Assist in equipping dialysis centers.

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

8 (B) The Department of Public Health shall:

9 (a) Assist in the development and expansion of programs
10 for the care and treatment of persons suffering from
11 chronic renal diseases, including dialysis and other
12 medical or surgical procedures and techniques that will
13 have a lifesaving effect in the care and treatment of
14 persons suffering from these diseases.

15 (b) Assist in the development of programs for the
16 prevention of chronic renal diseases.

17 (c) Institute and carry on an educational program among
18 physicians, hospitals, public health departments, and the
19 public concerning chronic renal diseases, including the
20 dissemination of information and the conducting of
21 educational programs concerning the prevention of chronic
22 renal diseases and the methods for the care and treatment
23 of persons suffering from these diseases.

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

25 Section 104. The Code of Civil Procedure is amended by

1 changing Section 5-105 as follows:

2 (735 ILCS 5/5-105) (from Ch. 110, par. 5-105)

3 Sec. 5-105. Leave to sue or defend as an indigent person.

4 (a) As used in this Section:

5 (1) "Fees, costs, and charges" means payments imposed
6 on a party in connection with the prosecution or defense of
7 a civil action, including, but not limited to: filing fees;
8 appearance fees; fees for service of process and other
9 papers served either within or outside this State,
10 including service by publication pursuant to Section 2-206
11 of this Code and publication of necessary legal notices;
12 motion fees; jury demand fees; charges for participation
13 in, or attendance at, any mandatory process or procedure
14 including, but not limited to, conciliation, mediation,
15 arbitration, counseling, evaluation, "Children First",
16 "Focus on Children" or similar programs; fees for
17 supplementary proceedings; charges for translation
18 services; guardian ad litem fees; charges for certified
19 copies of court documents; and all other processes and
20 procedures deemed by the court to be necessary to commence,
21 prosecute, defend, or enforce relief in a civil action.

22 (2) "Indigent person" means any person who meets one or
23 more of the following criteria:

24 (i) He or she is receiving assistance under one or
25 more of the following public benefits programs:

1 Supplemental Security Income (SSI), Aid to the Aged,
2 Blind and Disabled (AABD), Temporary Assistance for
3 Needy Families (TANF), Food Stamps, General
4 Assistance, ~~State~~ Transitional Assistance, or State
5 Children and Family Assistance.

6 (ii) His or her available income is 125% or less of
7 the current poverty level as established by the United
8 States Department of Health and Human Services, unless
9 the applicant's assets that are not exempt under Part 9
10 or 10 of Article XII of this Code are of a nature and
11 value that the court determines that the applicant is
12 able to pay the fees, costs, and charges.

13 (iii) He or she is, in the discretion of the court,
14 unable to proceed in an action without payment of fees,
15 costs, and charges and whose payment of those fees,
16 costs, and charges would result in substantial
17 hardship to the person or his or her family.

18 (iv) He or she is an indigent person pursuant to
19 Section 5-105.5 of this Code.

20 (b) On the application of any person, before, or after the
21 commencement of an action, a court, on finding that the
22 applicant is an indigent person, shall grant the applicant
23 leave to sue or defend the action without payment of the fees,
24 costs, and charges of the action.

25 (c) An application for leave to sue or defend an action as
26 an indigent person shall be in writing and supported by the

1 affidavit of the applicant or, if the applicant is a minor or
2 an incompetent adult, by the affidavit of another person having
3 knowledge of the facts. The contents of the affidavit shall be
4 established by Supreme Court Rule. The court shall provide,
5 through the office of the clerk of the court, simplified forms
6 consistent with the requirements of this Section and applicable
7 Supreme Court Rules to any person seeking to sue or defend an
8 action who indicates an inability to pay the fees, costs, and
9 charges of the action. The application and supporting affidavit
10 may be incorporated into one simplified form. The clerk of the
11 court shall post in a conspicuous place in the courthouse a
12 notice no smaller than 8.5 x 11 inches, using no smaller than
13 30-point typeface printed in English and in Spanish, advising
14 the public that they may ask the court for permission to sue or
15 defend a civil action without payment of fees, costs, and
16 charges. The notice shall be substantially as follows:

17 "If you are unable to pay the fees, costs, and charges
18 of an action you may ask the court to allow you to proceed
19 without paying them. Ask the clerk of the court for forms."

20 (d) The court shall rule on applications under this Section
21 in a timely manner based on information contained in the
22 application unless the court, in its discretion, requires the
23 applicant to personally appear to explain or clarify
24 information contained in the application. If the court finds
25 that the applicant is an indigent person, the court shall enter
26 an order permitting the applicant to sue or defend without

1 payment of fees, costs, or charges. If the application is
2 denied, the court shall enter an order to that effect stating
3 the specific reasons for the denial. The clerk of the court
4 shall promptly mail or deliver a copy of the order to the
5 applicant.

6 (e) The clerk of the court shall not refuse to accept and
7 file any complaint, appearance, or other paper presented by the
8 applicant if accompanied by an application to sue or defend in
9 forma pauperis, and those papers shall be considered filed on
10 the date the application is presented. If the application is
11 denied, the order shall state a date certain by which the
12 necessary fees, costs, and charges must be paid. The court, for
13 good cause shown, may allow an applicant whose application is
14 denied to defer payment of fees, costs, and charges, make
15 installment payments, or make payment upon reasonable terms and
16 conditions stated in the order. The court may dismiss the
17 claims or defenses of any party failing to pay the fees, costs,
18 or charges within the time and in the manner ordered by the
19 court. A determination concerning an application to sue or
20 defend in forma pauperis shall not be construed as a ruling on
21 the merits.

22 (f) The court may order an indigent person to pay all or a
23 portion of the fees, costs, or charges waived pursuant to this
24 Section out of moneys recovered by the indigent person pursuant
25 to a judgment or settlement resulting from the civil action.
26 However, nothing in ~~is~~ this Section shall be construed to limit

1 the authority of a court to order another party to the action
2 to pay the fees, costs, or charges of the action.

3 (g) A court, in its discretion, may appoint counsel to
4 represent an indigent person, and that counsel shall perform
5 his or her duties without fees, charges, or reward.

6 (h) Nothing in this Section shall be construed to affect
7 the right of a party to sue or defend an action in forma
8 pauperis without the payment of fees, costs, or charges, or the
9 right of a party to court-appointed counsel, as authorized by
10 any other provision of law or by the rules of the Illinois
11 Supreme Court.

12 (i) The provisions of this Section are severable under
13 Section 1.31 of the Statute on Statutes.

14 (Source: P.A. 91-621, eff. 8-19-99; revised 11-21-11.)

15 Section 105. The Unemployment Insurance Act is amended by
16 changing Sections 1400.2, 1402, 1404, 1405, 1801.1, and 1900 as
17 follows:

18 (820 ILCS 405/1400.2)

19 Sec. 1400.2. Annual reporting and paying; household
20 workers. This Section applies to an employer who solely employs
21 one or more household workers with respect to whom the employer
22 files federal unemployment taxes as part of his or her federal
23 income tax return, or could file federal unemployment taxes as
24 part of his or her federal income tax return if the worker or

1 workers were providing services in employment for purposes of
2 the federal unemployment tax. For purposes of this Section,
3 "household worker" has the meaning ascribed to it for purposes
4 of Section 3510 of the federal Internal Revenue Code. If an
5 employer to whom this Section applies notifies the Director, in
6 writing, that he or she wishes to pay his or her contributions
7 for each quarter and submit his or her wage ~~and contribution~~
8 reports for each month or quarter, as the case may be, on an
9 annual basis, then the due date for filing the reports and
10 paying the contributions shall be April 15 of the calendar year
11 immediately following the close of the months or quarters to
12 which the reports and quarters to which the contributions
13 apply, except that the Director may, by rule, establish a
14 different due date for good cause.

15 (Source: P.A. 94-723, eff. 1-19-06.)

16 (820 ILCS 405/1402) (from Ch. 48, par. 552)

17 Sec. 1402. Penalties.

18 A. If any employer fails, within the time prescribed in
19 this Act as amended and in effect on October 5, 1980, and the
20 regulations of the Director, to file a report of wages paid to
21 each of his workers, or to file a sufficient report of such
22 wages after having been notified by the Director to do so, for
23 any period which begins prior to January 1, 1982, he shall pay
24 to the Director as a penalty a sum determined in accordance
25 with the provisions of this Act as amended and in effect on

1 October 5, 1980.

2 B. Except as otherwise provided in this Section, any
3 employer who fails to file a report of wages paid to each of
4 his workers for any period which begins on or after January 1,
5 1982, within the time prescribed by the provisions of this Act
6 and the regulations of the Director, or, if the Director
7 pursuant to such regulations extends the time for filing the
8 report, fails to file it within the extended time, shall, in
9 addition to any sum otherwise payable by him under the
10 provisions of this Act, pay to the Director as a penalty a sum
11 equal to the lesser of (1) \$5 for each \$10,000 or fraction
12 thereof of the total wages for insured work paid by him during
13 the period or (2) \$2,500, for each month or part thereof of
14 such failure to file the report. With respect to an employer
15 who has elected to file reports of wages on an annual basis
16 pursuant to Section 1400.2, in assessing penalties for the
17 failure to submit all reports by the due date established
18 pursuant to that Section, the 30-day period immediately
19 following the due date shall be considered as one month.

20 If the Director deems an employer's report of wages paid to
21 each of his workers for any period which begins on or after
22 January 1, 1982, insufficient, he shall notify the employer to
23 file a sufficient report. If the employer fails to file such
24 sufficient report within 30 days after the mailing of the
25 notice to him, he shall, in addition to any sum otherwise
26 payable by him under the provisions of this Act, pay to the

1 Director as a penalty a sum determined in accordance with the
2 provisions of the first paragraph of this subsection, for each
3 month or part thereof of such failure to file such sufficient
4 report after the date of the notice.

5 For wages paid in calendar years prior to 1988, the penalty
6 or penalties which accrue under the two foregoing paragraphs
7 with respect to a report for any period shall not be less than
8 \$100, and shall not exceed the lesser of (1) \$10 for each
9 \$10,000 or fraction thereof of the total wages for insured work
10 paid during the period or (2) \$5,000. For wages paid in
11 calendar years after 1987, the penalty or penalties which
12 accrue under the 2 foregoing paragraphs with respect to a
13 report for any period shall not be less than \$50, and shall not
14 exceed the lesser of (1) \$10 for each \$10,000 or fraction of
15 the total wages for insured work paid during the period or (2)
16 \$5,000. With respect to an employer who has elected to file
17 reports of wages on an annual basis pursuant to Section 1400.2,
18 for purposes of calculating the minimum penalty prescribed by
19 this Section for failure to file the reports on a timely basis,
20 a calendar year shall constitute a single period. For reports
21 of wages paid after 1986, the Director shall not, however,
22 impose a penalty pursuant to either of the two foregoing
23 paragraphs on any employer who can prove within 30 working days
24 after the mailing of a notice of his failure to file such a
25 report, that (1) the failure to file the report is his first
26 such failure during the previous 20 consecutive calendar

1 quarters, and (2) the amount of the total contributions due for
2 the calendar quarter of such report (or, in the case of an
3 employer who is required to file the reports on a monthly
4 basis, the amount of the total contributions due for the
5 calendar quarter that includes the month of such report) is
6 less than \$500.

7 For any month which begins on or after January 1, 2013, a
8 report of the wages paid to each of an employer's workers shall
9 be due on or before the last day of the month next following
10 the calendar month in which the wages were paid if the employer
11 is required to report such wages electronically pursuant to the
12 regulations of the Director; otherwise a report of the wages
13 paid to each of the employer's workers shall be due on or
14 before the last day of the month next following the calendar
15 quarter in which the wages were paid.

16 Any employer who wilfully fails to pay any contribution or
17 part thereof, based upon wages paid prior to 1987, when
18 required by the provisions of this Act and the regulations of
19 the Director, with intent to defraud the Director, shall in
20 addition to such contribution or part thereof pay to the
21 Director a penalty equal to 50 percent of the amount of such
22 contribution or part thereof, as the case may be, provided that
23 the penalty shall not be less than \$200.

24 Any employer who willfully fails to pay any contribution or
25 part thereof, based upon wages paid in 1987 and in each
26 calendar year thereafter, when required by the provisions of

1 this Act and the regulations of the Director, with intent to
2 defraud the Director, shall in addition to such contribution or
3 part thereof pay to the Director a penalty equal to 60% of the
4 amount of such contribution or part thereof, as the case may
5 be, provided that the penalty shall not be less than \$400.

6 However, all or part of any penalty may be waived by the
7 Director for good cause shown.

8 (Source: P.A. 94-723, eff. 1-19-06.)

9 (820 ILCS 405/1404) (from Ch. 48, par. 554)

10 Sec. 1404. Payments in lieu of contributions by nonprofit
11 organizations. A. For the year 1972 and for each calendar year
12 thereafter, contributions shall accrue and become payable,
13 pursuant to Section 1400, by each nonprofit organization
14 (defined in Section 211.2) upon the wages paid by it with
15 respect to employment after 1971, unless the nonprofit
16 organization elects, in accordance with the provisions of this
17 Section, to pay, in lieu of contributions, an amount equal to
18 the amount of regular benefits and one-half the amount of
19 extended benefits (defined in Section 409) paid to individuals,
20 for any weeks which begin on or after the effective date of the
21 election, on the basis of wages for insured work paid to them
22 by such nonprofit organization during the effective period of
23 such election. Notwithstanding the preceding provisions of
24 this subsection and the provisions of subsection D, with
25 respect to benefit years beginning prior to July 1, 1989, any

1 adjustment after September 30, 1989 to the base period wages
2 paid to the individual by any employer shall not affect the
3 ratio for determining the payments in lieu of contributions of
4 a nonprofit organization which has elected to make payments in
5 lieu of contributions. Provided, however, that with respect to
6 benefit years beginning on or after July 1, 1989, the nonprofit
7 organization shall be required to make payments equal to 100%
8 of regular benefits, including dependents' allowances, and 50%
9 of extended benefits, including dependents' allowances, paid
10 to an individual with respect to benefit years beginning during
11 the effective period of the election, but only if the nonprofit
12 organization: (a) is the last employer as provided in Section
13 1502.1 and (b) paid to the individual receiving benefits, wages
14 for insured work during his base period. If the nonprofit
15 organization described in this paragraph meets the
16 requirements of (a) but not (b), with respect to benefit years
17 beginning on or after July 1, 1989, it shall be required to
18 make payments in an amount equal to 50% of regular benefits,
19 including dependents' allowances, and 25% of extended
20 benefits, including dependents' allowances, paid to an
21 individual with respect to benefit years beginning during the
22 effective period of the election.

23 1. Any employing unit which becomes a nonprofit
24 organization on January 1, 1972, may elect to make payments in
25 lieu of contributions for not less than one calendar year
26 beginning with January 1, 1972, provided that it files its

1 written election with the Director not later than January 31,
2 1972.

3 2. Any employing unit which becomes a nonprofit
4 organization after January 1, 1972, may elect to make payments
5 in lieu of contributions for a period of not less than one
6 calendar year beginning as of the first day with respect to
7 which it would, in the absence of its election, incur liability
8 for the payment of contributions, provided that it files its
9 written election with the Director not later than 30 days
10 immediately following the end of the calendar quarter in which
11 it becomes a nonprofit organization.

12 3. A nonprofit organization which has incurred liability
13 for the payment of contributions for at least 2 calendar years
14 and is not delinquent in such payment and in the payment of any
15 interest or penalties which may have accrued, may elect to make
16 payments in lieu of contributions beginning January 1 of any
17 calendar year, provided that it files its written election with
18 the Director prior to such January 1, and provided, further,
19 that such election shall be for a period of not less than 2
20 calendar years.

21 4. An election to make payments in lieu of contributions
22 shall not terminate any liability incurred by an employer for
23 the payment of contributions, interest or penalties with
24 respect to any calendar quarter (or month, as the case may be)
25 which ends prior to the effective period of the election.

26 5. A nonprofit organization which has elected, pursuant to

1 paragraph 1, 2, or 3, to make payments in lieu of contributions
2 may terminate the effective period of the election as of
3 January 1 of any calendar year subsequent to the required
4 minimum period of the election only if, prior to such January
5 1, it files with the Director a written notice to that effect.
6 Upon such termination, the organization shall become liable for
7 the payment of contributions upon wages for insured work paid
8 by it on and after such January 1 and, notwithstanding such
9 termination, it shall continue to be liable for payments in
10 lieu of contributions with respect to benefits paid to
11 individuals on and after such January 1, with respect to
12 benefit years beginning prior to July 1, 1989, on the basis of
13 wages for insured work paid to them by the nonprofit
14 organization prior to such January 1, and, with respect to
15 benefit years beginning after June 30, 1989, if such employer
16 was the last employer as provided in Section 1502.1 during a
17 benefit year beginning prior to such January 1.

18 6. Written elections to make payments in lieu of
19 contributions and written notices of termination of election
20 shall be filed in such form and shall contain such information
21 as the Director may prescribe. Upon the filing of such election
22 or notice, the Director shall either order it approved, or, if
23 it appears to the Director that the nonprofit organization has
24 not filed such election or notice within the time prescribed,
25 he shall order it disapproved. The Director shall serve notice
26 of his order upon the nonprofit organization. The Director's

1 order shall be final and conclusive upon the nonprofit
2 organization unless, within 15 days after the date of mailing
3 of notice thereof, the nonprofit organization files with the
4 Director an application for its review, setting forth its
5 reasons in support thereof. Upon receipt of an application for
6 review within the time prescribed, the Director shall order it
7 allowed, or shall order that it be denied, and shall serve
8 notice upon the nonprofit organization of his order. All of the
9 provisions of Section 1509, applicable to orders denying
10 applications for review of determinations of employers' rates
11 of contribution and not inconsistent with the provisions of
12 this subsection, shall be applicable to an order denying an
13 application for review filed pursuant to this subsection.

14 B. As soon as practicable following the close of each
15 calendar quarter, the Director shall mail to each nonprofit
16 organization which has elected to make payments in lieu of
17 contributions a Statement of the amount due from it for the
18 regular and one-half the extended benefits paid (or the amounts
19 otherwise provided for in subsection A) during the calendar
20 quarter, together with the names of its workers or former
21 workers and the amounts of benefits paid to each of them during
22 the calendar quarter, with respect to benefit years beginning
23 prior to July 1, 1989, on the basis of wages for insured work
24 paid to them by the nonprofit organization; or, with respect to
25 benefit years beginning after June 30, 1989, if such nonprofit
26 organization was the last employer as provided in Section

1 1502.1 with respect to a benefit year beginning during the
2 effective period of the election. The amount due shall be
3 payable, and the nonprofit organization shall make payment of
4 such amount not later than 30 days after the date of mailing of
5 the Statement. The Statement shall be final and conclusive upon
6 the nonprofit organization unless, within 20 days after the
7 date of mailing of the Statement, the nonprofit organization
8 files with the Director an application for revision thereof.
9 Such application shall specify wherein the nonprofit
10 organization believes the Statement to be incorrect, and shall
11 set forth its reasons for such belief. All of the provisions of
12 Section 1508, applicable to applications for revision of
13 Statements of Benefit Wages and Statements of Benefit Charges
14 and not inconsistent with the provisions of this subsection,
15 shall be applicable to an application for revision of a
16 Statement filed pursuant to this subsection.

17 1. Payments in lieu of contributions made by any nonprofit
18 organization shall not be deducted or deductible, in whole or
19 in part, from the remuneration of individuals in the employ of
20 the organization, nor shall any nonprofit organization require
21 or accept any waiver of any right under this Act by an
22 individual in its employ. The making of any such deduction or
23 the requirement or acceptance of any such waiver is a Class A
24 misdemeanor. Any agreement by an individual in the employ of
25 any person or concern to pay all or any portion of a payment in
26 lieu of contributions, required under this Act from a nonprofit

1 organization, is void.

2 2. A nonprofit organization which fails to make any payment
3 in lieu of contributions when due under the provisions of this
4 subsection shall pay interest thereon at the rates specified in
5 Section 1401. A nonprofit organization which has elected to
6 make payments in lieu of contributions shall be subject to the
7 penalty provisions of Section 1402. In the making of any
8 payment in lieu of contributions or in the payment of any
9 interest or penalties, a fractional part of a cent shall be
10 disregarded unless it amounts to one-half cent or more, in
11 which case it shall be increased to one cent.

12 3. All of the remedies available to the Director under the
13 provisions of this Act or of any other law to enforce the
14 payment of contributions, interest, or penalties under this
15 Act, including the making of determinations and assessments
16 pursuant to Section 2200, are applicable to the enforcement of
17 payments in lieu of contributions and of interest and
18 penalties, due under the provisions of this Section. For the
19 purposes of this paragraph, the term "contribution" or
20 "contributions" which appears in any such provision means
21 "payment in lieu of contributions" or "payments in lieu of
22 contributions." The term "contribution" which appears in
23 Section 2800 also means "payment in lieu of contributions."

24 4. All of the provisions of Sections 2201 and 2201.1,
25 applicable to adjustment or refund of contributions, interest
26 and penalties erroneously paid and not inconsistent with the

1 provisions of this Section, shall be applicable to payments in
2 lieu of contributions erroneously made or interest or penalties
3 erroneously paid by a nonprofit organization.

4 5. Payment in lieu of contributions shall be due with
5 respect to any sum erroneously paid as benefits to an
6 individual unless such sum has been recouped pursuant to
7 Section 900 or has otherwise been recovered. If such payment in
8 lieu of contributions has been made, the amount thereof shall
9 be adjusted or refunded in accordance with the provisions of
10 paragraph 4 and Section 2201 if recoupment or other recovery
11 has been made.

12 6. A nonprofit organization which has elected to make
13 payments in lieu of contributions and thereafter ceases to be
14 an employer shall continue to be liable for payments in lieu of
15 contributions with respect to benefits paid to individuals on
16 and after the date it has ceased to be an employer, with
17 respect to benefit years beginning prior to July 1, 1989, on
18 the basis of wages for insured work paid to them by it prior to
19 the date it ceased to be an employer, and, with respect to
20 benefit years beginning after June 30, 1989, if such employer
21 was the last employer as provided in Section 1502.1 prior to
22 the date that it ceased to be an employer.

23 7. With respect to benefit years beginning prior to July 1,
24 1989, wages paid to an individual during his base period, by a
25 nonprofit organization which elects to make payments in lieu of
26 contributions, for less than full time work, performed during

1 the same weeks in the base period during which the individual
2 had other insured work, shall not be subject to payments in
3 lieu of contributions (upon such employer's request pursuant to
4 the regulation of the Director) so long as the employer
5 continued after the end of the base period, and continues
6 during the applicable benefit year, to furnish such less than
7 full time work to the individual on the same basis and in
8 substantially the same amount as during the base period. If the
9 individual is paid benefits with respect to a week (in the
10 applicable benefit year) after the employer has ceased to
11 furnish the work hereinabove described, the nonprofit
12 organization shall be liable for payments in lieu of
13 contributions with respect to the benefits paid to the
14 individual after the date on which the nonprofit organization
15 ceases to furnish the work.

16 C. With respect to benefit years beginning prior to July 1,
17 1989, whenever benefits have been paid to an individual on the
18 basis of wages for insured work paid to him by a nonprofit
19 organization, and the organization incurred liability for the
20 payment of contributions on some of the wages because only a
21 part of the individual's base period was within the effective
22 period of the organization's written election to make payments
23 in lieu of contributions, the organization shall pay an amount
24 in lieu of contributions which bears the same ratio to the
25 total benefits paid to the individual as the total wages for
26 insured work paid to him during the base period by the

1 organization upon which it did not incur liability for the
2 payment of contributions (for the aforesaid reason) bear to the
3 total wages for insured work paid to the individual during the
4 base period by the organization.

5 D. With respect to benefit years beginning prior to July 1,
6 1989, whenever benefits have been paid to an individual on the
7 basis of wages for insured work paid to him by a nonprofit
8 organization which has elected to make payments in lieu of
9 contributions, and by one or more other employers, the
10 nonprofit organization shall pay an amount in lieu of
11 contributions which bears the same ratio to the total benefits
12 paid to the individual as the wages for insured work paid to
13 the individual during his base period by the nonprofit
14 organization bear to the total wages for insured work paid to
15 the individual during the base period by all of the employers.
16 If the nonprofit organization incurred liability for the
17 payment of contributions on some of the wages for insured work
18 paid to the individual, it shall be treated, with respect to
19 such wages, as one of the other employers for the purposes of
20 this paragraph.

21 E. Two or more nonprofit organizations which have elected
22 to make payments in lieu of contributions may file a joint
23 application with the Director for the establishment of a group
24 account, effective January 1 of any calendar year, for the
25 purpose of sharing the cost of benefits paid on the basis of
26 the wages for insured work paid by such nonprofit

1 organizations, provided that such joint application is filed
2 with the Director prior to such January 1. The application
3 shall identify and authorize a group representative to act as
4 the group's agent for the purposes of this paragraph, and shall
5 be filed in such form and shall contain such information as the
6 Director may prescribe. Upon his approval of a joint
7 application, the Director shall, by order, establish a group
8 account for the applicants and shall serve notice upon the
9 group's representative of such order. Such account shall remain
10 in effect for not less than 2 calendar years and thereafter
11 until terminated by the Director for good cause or, as of the
12 close of any calendar quarter, upon application by the group.
13 Upon establishment of the account, the group shall be liable to
14 the Director for payments in lieu of contributions in an amount
15 equal to the total amount for which, in the absence of the
16 group account, liability would have been incurred by all of its
17 members; provided, with respect to benefit years beginning
18 prior to July 1, 1989, that the liability of any member to the
19 Director with respect to any payment in lieu of contributions,
20 interest or penalties not paid by the group when due with
21 respect to any calendar quarter shall be in an amount which
22 bears the same ratio to the total benefits paid during such
23 quarter on the basis of the wages for insured work paid by all
24 members of the group as the total wages for insured work paid
25 by such member during such quarter bear to the total wages for
26 insured work paid during the quarter by all members of the

1 group, and, with respect to benefit years beginning on or after
2 July 1, 1989, that the liability of any member to the Director
3 with respect to any payment in lieu of contributions, interest
4 or penalties not paid by the group when due with respect to any
5 calendar quarter shall be in an amount which bears the same
6 ratio to the total benefits paid during such quarter to
7 individuals with respect to whom any member of the group was
8 the last employer as provided in Section 1502.1 as the total
9 wages for insured work paid by such member during such quarter
10 bear to the total wages for insured work paid during the
11 quarter by all members of the group. With respect to calendar
12 months and quarters beginning on or after January 1, 2013, the
13 liability of any member to the Director with respect to any
14 penalties that are assessed for failure to file a timely and
15 sufficient report of wages and which are not paid by the group
16 when due with respect to the calendar month or quarter, as the
17 case may be, shall be in an amount which bears the same ratio
18 to the total penalties due with respect to such month or
19 quarter as the total wages for insured work paid by such member
20 during such month or quarter bear to the total wages for
21 insured work paid during the month or quarter by all members of
22 the group. All of the provisions of this Section applicable to
23 nonprofit organizations which have elected to make payments in
24 lieu of contributions, and not inconsistent with the provisions
25 of this paragraph, shall apply to a group account and, upon its
26 termination, to each former member thereof. The Director shall

1 by regulation prescribe the conditions for establishment,
2 maintenance and termination of group accounts, and for addition
3 of new members to and withdrawal of active members from such
4 accounts.

5 F. Whenever service of notice is required by this Section,
6 such notice may be given and be complete by depositing it with
7 the United States Mail, addressed to the nonprofit organization
8 (or, in the case of a group account, to its representative) at
9 its last known address. If such organization is represented by
10 counsel in proceedings before the Director, service of notice
11 may be made upon the nonprofit organization by mailing the
12 notice to such counsel.

13 (Source: P.A. 86-3.)

14 (820 ILCS 405/1405) (from Ch. 48, par. 555)

15 Sec. 1405. Financing Benefits for Employees of Local
16 Governments.

17 A. 1. For the year 1978 and for each calendar year
18 thereafter, contributions shall accrue and become payable,
19 pursuant to Section 1400, by each governmental entity (other
20 than the State of Illinois and its wholly owned
21 instrumentalities) referred to in clause (B) of Section 211.1,
22 upon the wages paid by such entity with respect to employment
23 after 1977, unless the entity elects to make payments in lieu
24 of contributions pursuant to the provisions of subsection B.
25 Notwithstanding the provisions of Sections 1500 to 1510,

1 inclusive, a governmental entity which has not made such
2 election shall, for liability for contributions incurred prior
3 to January 1, 1984, pay contributions equal to 1 percent with
4 respect to wages for insured work paid during each such
5 calendar year or portion of such year as may be applicable. As
6 used in this subsection, the word "wages", defined in Section
7 234, is subject to all of the provisions of Section 235.

8 2. An Indian tribe for which service is exempted from the
9 federal unemployment tax under Section 3306(c)(7) of the
10 Federal Unemployment Tax Act may elect to make payments in lieu
11 of contributions in the same manner and subject to the same
12 conditions as provided in this Section with regard to
13 governmental entities, except as otherwise provided in
14 paragraphs 7, 8, and 9 of subsection B.

15 B. Any governmental entity subject to subsection A may
16 elect to make payments in lieu of contributions, in amounts
17 equal to the amounts of regular and extended benefits paid to
18 individuals, for any weeks which begin on or after the
19 effective date of the election, on the basis of wages for
20 insured work paid to them by the entity during the effective
21 period of such election. Notwithstanding the preceding
22 provisions of this subsection and the provisions of subsection
23 D of Section 1404, with respect to benefit years beginning
24 prior to July 1, 1989, any adjustment after September 30, 1989
25 to the base period wages paid to the individual by any employer
26 shall not affect the ratio for determining payments in lieu of

1 contributions of a governmental entity which has elected to
2 make payments in lieu of contributions. Provided, however, that
3 with respect to benefit years beginning on or after July 1,
4 1989, the governmental entity shall be required to make
5 payments equal to 100% of regular benefits, including
6 dependents' allowances, and 100% of extended benefits,
7 including dependents' allowances, paid to an individual with
8 respect to benefit years beginning during the effective period
9 of the election, but only if the governmental entity: (a) is
10 the last employer as provided in Section 1502.1 and (b) paid to
11 the individual receiving benefits, wages for insured work
12 during his base period. If the governmental entity described in
13 this paragraph meets the requirements of (a) but not (b), with
14 respect to benefit years beginning on or after July 1, 1989, it
15 shall be required to make payments in an amount equal to 50% of
16 regular benefits, including dependents' allowances, and 50% of
17 extended benefits, including dependents' allowances, paid to
18 an individual with respect to benefit years beginning during
19 the effective period of the election.

20 1. Any such governmental entity which becomes an employer
21 on January 1, 1978 pursuant to Section 205 may elect to make
22 payments in lieu of contributions for not less than one
23 calendar year beginning with January 1, 1978, provided that it
24 files its written election with the Director not later than
25 January 31, 1978.

26 2. A governmental entity newly created after January 1,

1 1978, may elect to make payments in lieu of contributions for a
2 period of not less than one calendar year beginning as of the
3 first day with respect to which it would, in the absence of its
4 election, incur liability for the payment of contributions,
5 provided that it files its written election with the Director
6 not later than 30 days immediately following the end of the
7 calendar quarter in which it has been created.

8 3. A governmental entity which has incurred liability for
9 the payment of contributions for at least 2 calendar years, and
10 is not delinquent in such payment and in the payment of any
11 interest or penalties which may have accrued, may elect to make
12 payments in lieu of contributions beginning January 1 of any
13 calendar year, provided that it files its written election with
14 the Director prior to such January 1, and provided, further,
15 that such election shall be for a period of not less than 2
16 calendar years.

17 4. An election to make payments in lieu of contributions
18 shall not terminate any liability incurred by a governmental
19 entity for the payment of contributions, interest or penalties
20 with respect to any calendar quarter (or month, as the case may
21 be) which ends prior to the effective period of the election.

22 5. The termination by a governmental entity of the
23 effective period of its election to make payments in lieu of
24 contributions, and the filing of and subsequent action upon
25 written notices of termination of election, shall be governed
26 by the provisions of paragraphs 5 and 6 of Section 1404A,

1 pertaining to nonprofit organizations.

2 6. With respect to benefit years beginning prior to July 1,
3 1989, wages paid to an individual during his base period by a
4 governmental entity which elects to make payments in lieu of
5 contributions for less than full time work, performed during
6 the same weeks in the base period during which the individual
7 had other insured work, shall not be subject to payments in
8 lieu of contribution (upon such employer's request pursuant to
9 the regulation of the Director) so long as the employer
10 continued after the end of the base period, and continues
11 during the applicable benefit year, to furnish such less than
12 full time work to the individual on the same basis and in
13 substantially the same amount as during the base period. If the
14 individual is paid benefits with respect to a week (in the
15 applicable benefit year) after the employer has ceased to
16 furnish the work hereinabove described, the governmental
17 entity shall be liable for payments in lieu of contributions
18 with respect to the benefits paid to the individual after the
19 date on which the governmental entity ceases to furnish the
20 work.

21 7. An Indian tribe may elect to make payments in lieu of
22 contributions for calendar year 2003, provided that it files
23 its written election with the Director not later than January
24 31, 2003, and provided further that it is not delinquent in the
25 payment of any contributions, interest, or penalties.

26 8. Failure of an Indian tribe to make a payment in lieu of

1 contributions, or a payment of interest or penalties due under
2 this Act, within 90 days after the Department serves notice of
3 the finality of a determination and assessment shall cause the
4 Indian tribe to lose the option of making payments in lieu of
5 contributions, effective as of the calendar year immediately
6 following the date on which the Department serves the notice.
7 Notice of the loss of the option to make payments in lieu of
8 contributions may be protested in the same manner as a
9 determination and assessment under Section 2200 of this Act.

10 9. An Indian tribe that, pursuant to paragraph 8, loses the
11 option of making payments in lieu of contributions may again
12 elect to make payments in lieu of contributions for a calendar
13 year if: (a) the Indian tribe has incurred liability for the
14 payment of contributions for at least one calendar year since
15 losing the option pursuant to paragraph 8, (b) the Indian tribe
16 is not delinquent in the payment of any liabilities under the
17 Act, including interest or penalties, and (c) the Indian tribe
18 files its written election with the Director not later than
19 January 31 of the year with respect to which it is making the
20 election.

21 C. As soon as practicable following the close of each
22 calendar quarter, the Director shall mail to each governmental
23 entity which has elected to make payments in lieu of
24 contributions a Statement of the amount due from it for all the
25 regular and extended benefits paid during the calendar quarter,
26 together with the names of its workers or former workers and

1 the amounts of benefits paid to each of them during the
2 calendar quarter with respect to benefit years beginning prior
3 to July 1, 1989, on the basis of wages for insured work paid to
4 them by the governmental entity; or, with respect to benefit
5 years beginning after June 30, 1989, if such governmental
6 entity was the last employer as provided in Section 1502.1 with
7 respect to a benefit year beginning during the effective period
8 of the election. All of the provisions of subsection B of
9 Section 1404 pertaining to nonprofit organizations, not
10 inconsistent with the preceding sentence, shall be applicable
11 to payments in lieu of contributions by a governmental entity.

12 D. The provisions of subsections C through F, inclusive, of
13 Section 1404, pertaining to nonprofit organizations, shall be
14 applicable to each governmental entity which has elected to
15 make payments in lieu of contributions.

16 E. 1. If an Indian tribe fails to pay any liability under
17 this Act (including assessments of interest or penalty) within
18 90 days after the Department issues a notice of the finality of
19 a determination and assessment, the Director shall immediately
20 notify the United States Internal Revenue Service and the
21 United States Department of Labor.

22 2. Notices of payment and reporting delinquencies to Indian
23 tribes shall include information that failure to make full
24 payment within the prescribed time frame:

25 a. will cause the Indian tribe to lose the exemption
26 provided by Section 3306(c) (7) of the Federal Unemployment

1 Tax Act with respect to the federal unemployment tax;

2 b. will cause the Indian tribe to lose the option to
3 make payments in lieu of contributions.

4 (Source: P.A. 92-555, eff. 6-24-02.)

5 (820 ILCS 405/1801.1)

6 Sec. 1801.1. Directory of New Hires.

7 A. The Director shall establish and operate an automated
8 directory of newly hired employees which shall be known as the
9 "Illinois Directory of New Hires" which shall contain the
10 information required to be reported by employers to the
11 Department under subsection B. In the administration of the
12 Directory, the Director shall comply with any requirements
13 concerning the Employer New Hire Reporting Program established
14 by the federal Personal Responsibility and Work Opportunity
15 Reconciliation Act of 1996. The Director is authorized to use
16 the information contained in the Directory of New Hires to
17 administer any of the provisions of this Act.

18 B. Each employer in Illinois, except a department, agency,
19 or instrumentality of the United States, shall file with the
20 Department a report in accordance with rules adopted by the
21 Department (but in any event not later than 20 days after the
22 date the employer hires the employee or, in the case of an
23 employer transmitting reports magnetically or electronically,
24 by 2 monthly transmissions, if necessary, not less than 12 days
25 nor more than 16 days apart) providing the following

1 information concerning each newly hired employee: the
2 employee's name, address, and social security number, the date
3 services for remuneration were first performed by the employee,
4 the employee's projected monthly wages, and the employer's
5 name, address, Federal Employer Identification Number assigned
6 under Section 6109 of the Internal Revenue Code of 1986, and
7 such other information as may be required by federal law or
8 regulation, provided that each employer may voluntarily file
9 the address to which the employer wants income withholding
10 orders to be mailed, if it is different from the address given
11 on the Federal Employer Identification Number. An employer in
12 Illinois which transmits its reports electronically or
13 magnetically and which also has employees in another state may
14 report all newly hired employees to a single designated state
15 in which the employer has employees if it has so notified the
16 Secretary of the United States Department of Health and Human
17 Services in writing. An employer may, at its option, submit
18 information regarding any rehired employee in the same manner
19 as information is submitted regarding a newly hired employee.
20 Each report required under this subsection shall, to the extent
21 practicable, be made on an Internal Revenue Service Form W-4
22 or, at the option of the employer, an equivalent form, and may
23 be transmitted by first class mail, by telefax, magnetically,
24 or electronically.

25 C. An employer which knowingly fails to comply with the
26 reporting requirements established by this Section shall be

1 subject to a civil penalty of \$15 for each individual whom it
2 fails to report. An employer shall be considered to have
3 knowingly failed to comply with the reporting requirements
4 established by this Section with respect to an individual if
5 the employer has been notified by the Department that it has
6 failed to report an individual, and it fails, without
7 reasonable cause, to supply the required information to the
8 Department within 21 days after the date of mailing of the
9 notice. Any individual who knowingly conspires with the newly
10 hired employee to cause the employer to fail to report the
11 information required by this Section or who knowingly conspires
12 with the newly hired employee to cause the employer to file a
13 false or incomplete report shall be guilty of a Class B
14 misdemeanor with a fine not to exceed \$500 with respect to each
15 employee with whom the individual so conspires.

16 D. As used in this Section, "newly hired employee" means an
17 individual who is an employee within the meaning of Chapter 24
18 of the Internal Revenue Code of 1986, and whose reporting to
19 work which results in earnings from the employer is the first
20 instance within the preceding 180 days that the individual has
21 reported for work for which earnings were received from that
22 employer; however, "newly hired employee" does not include an
23 employee of a federal or State agency performing intelligence
24 or counterintelligence functions, if the head of that agency
25 has determined that the filing of the report required by this
26 Section with respect to the employee could endanger the safety

1 of the employee or compromise an ongoing investigation or
2 intelligence mission.

3 Notwithstanding Section 205, and for the purposes of this
4 Section only, the term "employer" has the meaning given by
5 Section 3401(d) of the Internal Revenue Code of 1986 and
6 includes any governmental entity and labor organization as
7 defined by Section 2(5) of the National Labor Relations Act,
8 and includes any entity (also known as a hiring hall) which is
9 used by the organization and an employer to carry out the
10 requirements described in Section 8(f)(3) of that Act of an
11 agreement between the organization and the employer.

12 (Source: P.A. 97-621, eff. 11-18-11.)

13 (820 ILCS 405/1900) (from Ch. 48, par. 640)

14 Sec. 1900. Disclosure of information.

15 A. Except as provided in this Section, information obtained
16 from any individual or employing unit during the administration
17 of this Act shall:

18 1. be confidential,

19 2. not be published or open to public inspection,

20 3. not be used in any court in any pending action or
21 proceeding,

22 4. not be admissible in evidence in any action or
23 proceeding other than one arising out of this Act.

24 B. No finding, determination, decision, ruling or order
25 (including any finding of fact, statement or conclusion made

1 therein) issued pursuant to this Act shall be admissible or
2 used in evidence in any action other than one arising out of
3 this Act, nor shall it be binding or conclusive except as
4 provided in this Act, nor shall it constitute res judicata,
5 regardless of whether the actions were between the same or
6 related parties or involved the same facts.

7 C. Any officer or employee of this State, any officer or
8 employee of any entity authorized to obtain information
9 pursuant to this Section, and any agent of this State or of
10 such entity who, except with authority of the Director under
11 this Section, shall disclose information shall be guilty of a
12 Class B misdemeanor and shall be disqualified from holding any
13 appointment or employment by the State.

14 D. An individual or his duly authorized agent may be
15 supplied with information from records only to the extent
16 necessary for the proper presentation of his claim for benefits
17 or with his existing or prospective rights to benefits.
18 Discretion to disclose this information belongs solely to the
19 Director and is not subject to a release or waiver by the
20 individual. Notwithstanding any other provision to the
21 contrary, an individual or his or her duly authorized agent may
22 be supplied with a statement of the amount of benefits paid to
23 the individual during the 18 months preceding the date of his
24 or her request.

25 E. An employing unit may be furnished with information,
26 only if deemed by the Director as necessary to enable it to

1 fully discharge its obligations or safeguard its rights under
2 the Act. Discretion to disclose this information belongs solely
3 to the Director and is not subject to a release or waiver by
4 the employing unit.

5 F. The Director may furnish any information that he may
6 deem proper to any public officer or public agency of this or
7 any other State or of the federal government dealing with:

- 8 1. the administration of relief,
- 9 2. public assistance,
- 10 3. unemployment compensation,
- 11 4. a system of public employment offices,
- 12 5. wages and hours of employment, or
- 13 6. a public works program.

14 The Director may make available to the Illinois Workers'
15 Compensation Commission information regarding employers for
16 the purpose of verifying the insurance coverage required under
17 the Workers' Compensation Act and Workers' Occupational
18 Diseases Act.

19 G. The Director may disclose information submitted by the
20 State or any of its political subdivisions, municipal
21 corporations, instrumentalities, or school or community
22 college districts, except for information which specifically
23 identifies an individual claimant.

24 H. The Director shall disclose only that information
25 required to be disclosed under Section 303 of the Social
26 Security Act, as amended, including:

1 1. any information required to be given the United
2 States Department of Labor under Section 303(a)(6); and

3 2. the making available upon request to any agency of
4 the United States charged with the administration of public
5 works or assistance through public employment, the name,
6 address, ordinary occupation and employment status of each
7 recipient of unemployment compensation, and a statement of
8 such recipient's right to further compensation under such
9 law as required by Section 303(a)(7); and

10 3. records to make available to the Railroad Retirement
11 Board as required by Section 303(c)(1); and

12 4. information that will assure reasonable cooperation
13 with every agency of the United States charged with the
14 administration of any unemployment compensation law as
15 required by Section 303(c)(2); and

16 5. information upon request and on a reimbursable basis
17 to the United States Department of Agriculture and to any
18 State food stamp agency concerning any information
19 required to be furnished by Section 303(d); and

20 6. any wage information upon request and on a
21 reimbursable basis to any State or local child support
22 enforcement agency required by Section 303(e); and

23 7. any information required under the income
24 eligibility and verification system as required by Section
25 303(f); and

26 8. information that might be useful in locating an

1 absent parent or that parent's employer, establishing
2 paternity or establishing, modifying, or enforcing child
3 support orders for the purpose of a child support
4 enforcement program under Title IV of the Social Security
5 Act upon the request of and on a reimbursable basis to the
6 public agency administering the Federal Parent Locator
7 Service as required by Section 303(h); and

8 9. information, upon request, to representatives of
9 any federal, State or local governmental public housing
10 agency with respect to individuals who have signed the
11 appropriate consent form approved by the Secretary of
12 Housing and Urban Development and who are applying for or
13 participating in any housing assistance program
14 administered by the United States Department of Housing and
15 Urban Development as required by Section 303(i).

16 I. The Director, upon the request of a public agency of
17 Illinois, of the federal government or of any other state
18 charged with the investigation or enforcement of Section 10-5
19 of the Criminal Code of 1961 (or a similar federal law or
20 similar law of another State), may furnish the public agency
21 information regarding the individual specified in the request
22 as to:

23 1. the current or most recent home address of the
24 individual, and

25 2. the names and addresses of the individual's
26 employers.

1 J. Nothing in this Section shall be deemed to interfere
2 with the disclosure of certain records as provided for in
3 Section 1706 or with the right to make available to the
4 Internal Revenue Service of the United States Department of the
5 Treasury, or the Department of Revenue of the State of
6 Illinois, information obtained under this Act.

7 K. The Department shall make available to the Illinois
8 Student Assistance Commission, upon request, information in
9 the possession of the Department that may be necessary or
10 useful to the Commission in the collection of defaulted or
11 delinquent student loans which the Commission administers.

12 L. The Department shall make available to the State
13 Employees' Retirement System, the State Universities
14 Retirement System, the Teachers' Retirement System of the State
15 of Illinois, and the Department of Central Management Services,
16 Risk Management Division, upon request, information in the
17 possession of the Department that may be necessary or useful to
18 the System or the Risk Management Division for the purpose of
19 determining whether any recipient of a disability benefit from
20 the System or a workers' compensation benefit from the Risk
21 Management Division is gainfully employed.

22 M. This Section shall be applicable to the information
23 obtained in the administration of the State employment service,
24 except that the Director may publish or release general labor
25 market information and may furnish information that he may deem
26 proper to an individual, public officer or public agency of

1 this or any other State or the federal government (in addition
2 to those public officers or public agencies specified in this
3 Section) as he prescribes by Rule.

4 N. The Director may require such safeguards as he deems
5 proper to insure that information disclosed pursuant to this
6 Section is used only for the purposes set forth in this
7 Section.

8 O. Nothing in this Section prohibits communication with an
9 individual or entity through unencrypted e-mail or other
10 unencrypted electronic means as long as the communication does
11 not contain the individual's or entity's name in combination
12 with any one or more of the individual's or entity's social
13 security number; driver's license or State identification
14 number; account number or credit or debit card number; or any
15 required security code, access code, or password that would
16 permit access to further information pertaining to the
17 individual or entity.

18 P. Within 30 days after the effective date of this
19 amendatory Act of 1993 and annually thereafter, the Department
20 shall provide to the Department of Financial Institutions a
21 list of individuals or entities that, for the most recently
22 completed calendar year, report to the Department as paying
23 wages to workers. The lists shall be deemed confidential and
24 may not be disclosed to any other person.

25 Q. The Director shall make available to an elected federal
26 official the name and address of an individual or entity that

1 is located within the jurisdiction from which the official was
2 elected and that, for the most recently completed calendar
3 year, has reported to the Department as paying wages to
4 workers, where the information will be used in connection with
5 the official duties of the official and the official requests
6 the information in writing, specifying the purposes for which
7 it will be used. For purposes of this subsection, the use of
8 information in connection with the official duties of an
9 official does not include use of the information in connection
10 with the solicitation of contributions or expenditures, in
11 money or in kind, to or on behalf of a candidate for public or
12 political office or a political party or with respect to a
13 public question, as defined in Section 1-3 of the Election
14 Code, or in connection with any commercial solicitation. Any
15 elected federal official who, in submitting a request for
16 information covered by this subsection, knowingly makes a false
17 statement or fails to disclose a material fact, with the intent
18 to obtain the information for a purpose not authorized by this
19 subsection, shall be guilty of a Class B misdemeanor.

20 R. The Director may provide to any State or local child
21 support agency, upon request and on a reimbursable basis,
22 information that might be useful in locating an absent parent
23 or that parent's employer, establishing paternity, or
24 establishing, modifying, or enforcing child support orders.

25 S. The Department shall make available to a State's
26 Attorney of this State or a State's Attorney's investigator,

1 upon request, the current address or, if the current address is
2 unavailable, current employer information, if available, of a
3 victim of a felony or a witness to a felony or a person against
4 whom an arrest warrant is outstanding.

5 T. The Director shall make available to the Department of
6 State Police, a county sheriff's office, or a municipal police
7 department, upon request, any information concerning the
8 current address and place of employment or former places of
9 employment of a person who is required to register as a sex
10 offender under the Sex Offender Registration Act that may be
11 useful in enforcing the registration provisions of that Act.

12 U. The Director shall make information available to the
13 Department of Healthcare and Family Services and the Department
14 of Human Services for the purpose of determining eligibility
15 for public benefit programs authorized under the Illinois
16 Public Aid Code and related statutes administered by those
17 departments, for verifying sources and amounts of income, and
18 for other purposes directly connected with the administration
19 of those programs.

20 (Source: P.A. 96-420, eff. 8-13-09; 97-621, eff. 11-18-11.)

21 Section 905. The State Comptroller Act is amended by
22 changing Section 10.05 as follows:

23 (15 ILCS 405/10.05) (from Ch. 15, par. 210.05)

24 Sec. 10.05. Deductions from warrants; statement of reason

1 for deduction. Whenever any person shall be entitled to a
2 warrant or other payment from the treasury or other funds held
3 by the State Treasurer, on any account, against whom there
4 shall be any then due and payable account or claim in favor of
5 the State, the United States upon certification by the
6 Secretary of the Treasury of the United States, or his or her
7 delegate, pursuant to a reciprocal offset agreement under
8 subsection (i-1) of Section 10 of the Illinois State Collection
9 Act of 1986, or a unit of local government, a school district,
10 or a public institution of higher education, as defined in
11 Section 1 of the Board of Higher Education Act, upon
12 certification by that entity, the Comptroller, upon
13 notification thereof, shall ascertain the amount due and
14 payable to the State, the United States, the unit of local
15 government, the school district, or the public institution of
16 higher education, as aforesaid, and draw a warrant on the
17 treasury or on other funds held by the State Treasurer, stating
18 the amount for which the party was entitled to a warrant or
19 other payment, the amount deducted therefrom, and on what
20 account, and directing the payment of the balance; which
21 warrant or payment as so drawn shall be entered on the books of
22 the Treasurer, and such balance only shall be paid. The
23 Comptroller may deduct any one or more of the following: (i)
24 the entire amount due and payable to the State or a portion of
25 the amount due and payable to the State in accordance with the
26 request of the notifying agency; (ii) the entire amount due and

1 payable to the United States or a portion of the amount due and
2 payable to the United States in accordance with a reciprocal
3 offset agreement under subsection (i-1) of Section 10 of the
4 Illinois State Collection Act of 1986; or (iii) the entire
5 amount due and payable to the unit of local government, school
6 district, or public institution of higher education or a
7 portion of the amount due and payable to that entity in
8 accordance with an intergovernmental agreement authorized
9 under this Section and Section 10.05d. No request from a
10 notifying agency, the Secretary of the Treasury of the United
11 States, a unit of local government, a school district, or a
12 public institution of higher education for an amount to be
13 deducted under this Section from a wage or salary payment, or
14 from a contractual payment to an individual for personal
15 services, shall exceed 25% of the net amount of such payment.
16 "Net amount" means that part of the earnings of an individual
17 remaining after deduction of any amounts required by law to be
18 withheld. For purposes of this provision, wage, salary or other
19 payments for personal services shall not include final
20 compensation payments for the value of accrued vacation,
21 overtime or sick leave. Whenever the Comptroller draws a
22 warrant or makes a payment involving a deduction ordered under
23 this Section, the Comptroller shall notify the payee and the
24 State agency that submitted the voucher of the reason for the
25 deduction and he or she shall retain a record of such statement
26 in his or her records. As used in this Section, an "account or

1 claim in favor of the State" includes all amounts owing to
2 "State agencies" as defined in Section 7 of this Act. However,
3 the Comptroller shall not be required to accept accounts or
4 claims owing to funds not held by the State Treasurer, where
5 such accounts or claims do not exceed \$50, nor shall the
6 Comptroller deduct from funds held by the State Treasurer under
7 the Senior Citizens and Disabled Persons Property Tax Relief
8 ~~and Pharmaceutical Assistance~~ Act or for payments to
9 institutions from the Illinois Prepaid Tuition Trust Fund
10 (unless the Trust Fund moneys are used for child support). The
11 Comptroller and the Department of Revenue shall enter into an
12 interagency agreement to establish responsibilities, duties,
13 and procedures relating to deductions from lottery prizes
14 awarded under Section 20.1 of the Illinois Lottery Law. The
15 Comptroller may enter into an intergovernmental agreement with
16 the Department of Revenue and the Secretary of the Treasury of
17 the United States, or his or her delegate, to establish
18 responsibilities, duties, and procedures relating to
19 reciprocal offset of delinquent State and federal obligations
20 pursuant to subsection (i-1) of Section 10 of the Illinois
21 State Collection Act of 1986. The Comptroller may enter into
22 intergovernmental agreements with any unit of local
23 government, school district, or public institution of higher
24 education to establish responsibilities, duties, and
25 procedures to provide for the offset, by the Comptroller, of
26 obligations owed to those entities.

1 (Source: P.A. 97-269, eff. 12-16-11 (see Section 15 of P.A.
2 97-632 for the effective date of changes made by P.A. 97-269);
3 97-632, eff. 12-16-11.)

4 Section 910. The State Finance Act is amended by changing
5 Section 6z-81 as follows:

6 (30 ILCS 105/6z-81)

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

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

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

13 (1) Subject to appropriation, for payment by the
14 Department of Healthcare and Family Services or by the
15 Department of Human Services of medical bills and related
16 expenses, including administrative expenses, for which the
17 State is responsible under Titles XIX and XXI of the Social
18 Security Act, the Illinois Public Aid Code, the Children's
19 Health Insurance Program Act, the Covering ALL KIDS Health
20 Insurance Act, and the Long Term Acute Care Hospital
21 Quality Improvement Transfer Program Act. ~~, and the Senior~~
22 ~~Citizens and Disabled Persons Property Tax Relief and~~
23 ~~Pharmaceutical Assistance Act.~~

24 (2) For repayment of funds borrowed from other State

1 funds or from outside sources, including interest thereon.

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

3 (1) Moneys received by the State from short-term
4 borrowing pursuant to the Short Term Borrowing Act on or
5 after the effective date of this amendatory Act of the 96th
6 General Assembly.

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

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

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

17 (d) In addition to any other transfers that may be provided
18 for by law, on the effective date of this amendatory Act of the
19 97th General Assembly, or as soon thereafter as practical, the
20 State Comptroller shall direct and the State Treasurer shall
21 transfer the sum of \$365,000,000 from the General Revenue Fund
22 into the Healthcare Provider Relief Fund.

23 (e) In addition to any other transfers that may be provided
24 for by law, on July 1, 2011, or as soon thereafter as
25 practical, the State Comptroller shall direct and the State
26 Treasurer shall transfer the sum of \$160,000,000 from the

1 General Revenue Fund to the Healthcare Provider Relief Fund.

2 (Source: P.A. 96-820, eff. 11-18-09; 96-1100, eff. 1-1-11;
3 97-44, eff. 6-28-11; 97-641, eff. 12-19-11.)

4 Section 915. The Downstate Public Transportation Act is
5 amended by changing Sections 2-15.2 and 2-15.3 as follows:

6 (30 ILCS 740/2-15.2)

7 Sec. 2-15.2. Free services; eligibility.

8 (a) Notwithstanding any law to the contrary, no later than
9 60 days following the effective date of this amendatory Act of
10 the 95th General Assembly and until subsection (b) is
11 implemented, any fixed route public transportation services
12 provided by, or under grant or purchase of service contracts
13 of, every participant, as defined in Section 2-2.02 (1)(a),
14 shall be provided without charge to all senior citizen
15 residents of the participant aged 65 and older, under such
16 conditions as shall be prescribed by the participant.

17 (b) Notwithstanding any law to the contrary, no later than
18 180 days following the effective date of this amendatory Act of
19 the 96th General Assembly, any fixed route public
20 transportation services provided by, or under grant or purchase
21 of service contracts of, every participant, as defined in
22 Section 2-2.02 (1)(a), shall be provided without charge to
23 senior citizens aged 65 and older who meet the income
24 eligibility limitation set forth in subsection (a-5) of Section

1 4 of the Senior Citizens and Disabled Persons Property Tax
2 Relief ~~and Pharmaceutical Assistance~~ Act, under such
3 conditions as shall be prescribed by the participant. The
4 Department on Aging shall furnish all information reasonably
5 necessary to determine eligibility, including updated lists of
6 individuals who are eligible for services without charge under
7 this Section. Nothing in this Section shall relieve the
8 participant from providing reduced fares as may be required by
9 federal law.

10 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

11 (30 ILCS 740/2-15.3)

12 Sec. 2-15.3. Transit services for disabled individuals.
13 Notwithstanding any law to the contrary, no later than 60 days
14 following the effective date of this amendatory Act of the 95th
15 General Assembly, all fixed route public transportation
16 services provided by, or under grant or purchase of service
17 contract of, any participant shall be provided without charge
18 to all disabled persons who meet the income eligibility
19 limitation set forth in subsection (a-5) of Section 4 of the
20 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
21 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
22 be prescribed by the participant. The Department on Aging shall
23 furnish all information reasonably necessary to determine
24 eligibility, including updated lists of individuals who are
25 eligible for services without charge under this Section.

1 (Source: P.A. 95-906, eff. 8-26-08.)

2 Section 920. The Property Tax Code is amended by changing
3 Sections 15-172, 15-175, 20-15, and 21-27 as follows:

4 (35 ILCS 200/15-172)

5 Sec. 15-172. Senior Citizens Assessment Freeze Homestead
6 Exemption.

7 (a) This Section may be cited as the Senior Citizens
8 Assessment Freeze Homestead Exemption.

9 (b) As used in this Section:

10 "Applicant" means an individual who has filed an
11 application under this Section.

12 "Base amount" means the base year equalized assessed value
13 of the residence plus the first year's equalized assessed value
14 of any added improvements which increased the assessed value of
15 the residence after the base year.

16 "Base year" means the taxable year prior to the taxable
17 year for which the applicant first qualifies and applies for
18 the exemption provided that in the prior taxable year the
19 property was improved with a permanent structure that was
20 occupied as a residence by the applicant who was liable for
21 paying real property taxes on the property and who was either
22 (i) an owner of record of the property or had legal or
23 equitable interest in the property as evidenced by a written
24 instrument or (ii) had a legal or equitable interest as a

1 lessee in the parcel of property that was single family
2 residence. If in any subsequent taxable year for which the
3 applicant applies and qualifies for the exemption the equalized
4 assessed value of the residence is less than the equalized
5 assessed value in the existing base year (provided that such
6 equalized assessed value is not based on an assessed value that
7 results from a temporary irregularity in the property that
8 reduces the assessed value for one or more taxable years), then
9 that subsequent taxable year shall become the base year until a
10 new base year is established under the terms of this paragraph.
11 For taxable year 1999 only, the Chief County Assessment Officer
12 shall review (i) all taxable years for which the applicant
13 applied and qualified for the exemption and (ii) the existing
14 base year. The assessment officer shall select as the new base
15 year the year with the lowest equalized assessed value. An
16 equalized assessed value that is based on an assessed value
17 that results from a temporary irregularity in the property that
18 reduces the assessed value for one or more taxable years shall
19 not be considered the lowest equalized assessed value. The
20 selected year shall be the base year for taxable year 1999 and
21 thereafter until a new base year is established under the terms
22 of this paragraph.

23 "Chief County Assessment Officer" means the County
24 Assessor or Supervisor of Assessments of the county in which
25 the property is located.

26 "Equalized assessed value" means the assessed value as

1 equalized by the Illinois Department of Revenue.

2 "Household" means the applicant, the spouse of the
3 applicant, and all persons using the residence of the applicant
4 as their principal place of residence.

5 "Household income" means the combined income of the members
6 of a household for the calendar year preceding the taxable
7 year.

8 "Income" has the same meaning as provided in Section 3.07
9 of the Senior Citizens and Disabled Persons Property Tax Relief
10 ~~and Pharmaceutical Assistance Act~~, except that, beginning in
11 assessment year 2001, "income" does not include veteran's
12 benefits.

13 "Internal Revenue Code of 1986" means the United States
14 Internal Revenue Code of 1986 or any successor law or laws
15 relating to federal income taxes in effect for the year
16 preceding the taxable year.

17 "Life care facility that qualifies as a cooperative" means
18 a facility as defined in Section 2 of the Life Care Facilities
19 Act.

20 "Maximum income limitation" means:

- 21 (1) \$35,000 prior to taxable year 1999;
- 22 (2) \$40,000 in taxable years 1999 through 2003;
- 23 (3) \$45,000 in taxable years 2004 through 2005;
- 24 (4) \$50,000 in taxable years 2006 and 2007; and
- 25 (5) \$55,000 in taxable year 2008 and thereafter.

26 "Residence" means the principal dwelling place and

1 appurtenant structures used for residential purposes in this
2 State occupied on January 1 of the taxable year by a household
3 and so much of the surrounding land, constituting the parcel
4 upon which the dwelling place is situated, as is used for
5 residential purposes. If the Chief County Assessment Officer
6 has established a specific legal description for a portion of
7 property constituting the residence, then that portion of
8 property shall be deemed the residence for the purposes of this
9 Section.

10 "Taxable year" means the calendar year during which ad
11 valorem property taxes payable in the next succeeding year are
12 levied.

13 (c) Beginning in taxable year 1994, a senior citizens
14 assessment freeze homestead exemption is granted for real
15 property that is improved with a permanent structure that is
16 occupied as a residence by an applicant who (i) is 65 years of
17 age or older during the taxable year, (ii) has a household
18 income that does not exceed the maximum income limitation,
19 (iii) is liable for paying real property taxes on the property,
20 and (iv) is an owner of record of the property or has a legal or
21 equitable interest in the property as evidenced by a written
22 instrument. This homestead exemption shall also apply to a
23 leasehold interest in a parcel of property improved with a
24 permanent structure that is a single family residence that is
25 occupied as a residence by a person who (i) is 65 years of age
26 or older during the taxable year, (ii) has a household income

1 that does not exceed the maximum income limitation, (iii) has a
2 legal or equitable ownership interest in the property as
3 lessee, and (iv) is liable for the payment of real property
4 taxes on that property.

5 In counties of 3,000,000 or more inhabitants, the amount of
6 the exemption for all taxable years is the equalized assessed
7 value of the residence in the taxable year for which
8 application is made minus the base amount. In all other
9 counties, the amount of the exemption is as follows: (i)
10 through taxable year 2005 and for taxable year 2007 and
11 thereafter, the amount of this exemption shall be the equalized
12 assessed value of the residence in the taxable year for which
13 application is made minus the base amount; and (ii) for taxable
14 year 2006, the amount of the exemption is as follows:

15 (1) For an applicant who has a household income of
16 \$45,000 or less, the amount of the exemption is the
17 equalized assessed value of the residence in the taxable
18 year for which application is made minus the base amount.

19 (2) For an applicant who has a household income
20 exceeding \$45,000 but not exceeding \$46,250, the amount of
21 the exemption is (i) the equalized assessed value of the
22 residence in the taxable year for which application is made
23 minus the base amount (ii) multiplied by 0.8.

24 (3) For an applicant who has a household income
25 exceeding \$46,250 but not exceeding \$47,500, the amount of
26 the exemption is (i) the equalized assessed value of the

1 residence in the taxable year for which application is made
2 minus the base amount (ii) multiplied by 0.6.

3 (4) For an applicant who has a household income
4 exceeding \$47,500 but not exceeding \$48,750, the amount of
5 the exemption is (i) the equalized assessed value of the
6 residence in the taxable year for which application is made
7 minus the base amount (ii) multiplied by 0.4.

8 (5) For an applicant who has a household income
9 exceeding \$48,750 but not exceeding \$50,000, the amount of
10 the exemption is (i) the equalized assessed value of the
11 residence in the taxable year for which application is made
12 minus the base amount (ii) multiplied by 0.2.

13 When the applicant is a surviving spouse of an applicant
14 for a prior year for the same residence for which an exemption
15 under this Section has been granted, the base year and base
16 amount for that residence are the same as for the applicant for
17 the prior year.

18 Each year at the time the assessment books are certified to
19 the County Clerk, the Board of Review or Board of Appeals shall
20 give to the County Clerk a list of the assessed values of
21 improvements on each parcel qualifying for this exemption that
22 were added after the base year for this parcel and that
23 increased the assessed value of the property.

24 In the case of land improved with an apartment building
25 owned and operated as a cooperative or a building that is a
26 life care facility that qualifies as a cooperative, the maximum

1 reduction from the equalized assessed value of the property is
2 limited to the sum of the reductions calculated for each unit
3 occupied as a residence by a person or persons (i) 65 years of
4 age or older, (ii) with a household income that does not exceed
5 the maximum income limitation, (iii) who is liable, by contract
6 with the owner or owners of record, for paying real property
7 taxes on the property, and (iv) who is an owner of record of a
8 legal or equitable interest in the cooperative apartment
9 building, other than a leasehold interest. In the instance of a
10 cooperative where a homestead exemption has been granted under
11 this Section, the cooperative association or its management
12 firm shall credit the savings resulting from that exemption
13 only to the apportioned tax liability of the owner who
14 qualified for the exemption. Any person who willfully refuses
15 to credit that savings to an owner who qualifies for the
16 exemption is guilty of a Class B misdemeanor.

17 When a homestead exemption has been granted under this
18 Section and an applicant then becomes a resident of a facility
19 licensed under the Assisted Living and Shared Housing Act, the
20 Nursing Home Care Act, the Specialized Mental Health
21 Rehabilitation Act, or the ID/DD Community Care Act, the
22 exemption shall be granted in subsequent years so long as the
23 residence (i) continues to be occupied by the qualified
24 applicant's spouse or (ii) if remaining unoccupied, is still
25 owned by the qualified applicant for the homestead exemption.

26 Beginning January 1, 1997, when an individual dies who

1 would have qualified for an exemption under this Section, and
2 the surviving spouse does not independently qualify for this
3 exemption because of age, the exemption under this Section
4 shall be granted to the surviving spouse for the taxable year
5 preceding and the taxable year of the death, provided that,
6 except for age, the surviving spouse meets all other
7 qualifications for the granting of this exemption for those
8 years.

9 When married persons maintain separate residences, the
10 exemption provided for in this Section may be claimed by only
11 one of such persons and for only one residence.

12 For taxable year 1994 only, in counties having less than
13 3,000,000 inhabitants, to receive the exemption, a person shall
14 submit an application by February 15, 1995 to the Chief County
15 Assessment Officer of the county in which the property is
16 located. In counties having 3,000,000 or more inhabitants, for
17 taxable year 1994 and all subsequent taxable years, to receive
18 the exemption, a person may submit an application to the Chief
19 County Assessment Officer of the county in which the property
20 is located during such period as may be specified by the Chief
21 County Assessment Officer. The Chief County Assessment Officer
22 in counties of 3,000,000 or more inhabitants shall annually
23 give notice of the application period by mail or by
24 publication. In counties having less than 3,000,000
25 inhabitants, beginning with taxable year 1995 and thereafter,
26 to receive the exemption, a person shall submit an application

1 by July 1 of each taxable year to the Chief County Assessment
2 Officer of the county in which the property is located. A
3 county may, by ordinance, establish a date for submission of
4 applications that is different than July 1. The applicant shall
5 submit with the application an affidavit of the applicant's
6 total household income, age, marital status (and if married the
7 name and address of the applicant's spouse, if known), and
8 principal dwelling place of members of the household on January
9 1 of the taxable year. The Department shall establish, by rule,
10 a method for verifying the accuracy of affidavits filed by
11 applicants under this Section, and the Chief County Assessment
12 Officer may conduct audits of any taxpayer claiming an
13 exemption under this Section to verify that the taxpayer is
14 eligible to receive the exemption. Each application shall
15 contain or be verified by a written declaration that it is made
16 under the penalties of perjury. A taxpayer's signing a
17 fraudulent application under this Act is perjury, as defined in
18 Section 32-2 of the Criminal Code of 1961. The applications
19 shall be clearly marked as applications for the Senior Citizens
20 Assessment Freeze Homestead Exemption and must contain a notice
21 that any taxpayer who receives the exemption is subject to an
22 audit by the Chief County Assessment Officer.

23 Notwithstanding any other provision to the contrary, in
24 counties having fewer than 3,000,000 inhabitants, if an
25 applicant fails to file the application required by this
26 Section in a timely manner and this failure to file is due to a

1 mental or physical condition sufficiently severe so as to
2 render the applicant incapable of filing the application in a
3 timely manner, the Chief County Assessment Officer may extend
4 the filing deadline for a period of 30 days after the applicant
5 regains the capability to file the application, but in no case
6 may the filing deadline be extended beyond 3 months of the
7 original filing deadline. In order to receive the extension
8 provided in this paragraph, the applicant shall provide the
9 Chief County Assessment Officer with a signed statement from
10 the applicant's physician stating the nature and extent of the
11 condition, that, in the physician's opinion, the condition was
12 so severe that it rendered the applicant incapable of filing
13 the application in a timely manner, and the date on which the
14 applicant regained the capability to file the application.

15 Beginning January 1, 1998, notwithstanding any other
16 provision to the contrary, in counties having fewer than
17 3,000,000 inhabitants, if an applicant fails to file the
18 application required by this Section in a timely manner and
19 this failure to file is due to a mental or physical condition
20 sufficiently severe so as to render the applicant incapable of
21 filing the application in a timely manner, the Chief County
22 Assessment Officer may extend the filing deadline for a period
23 of 3 months. In order to receive the extension provided in this
24 paragraph, the applicant shall provide the Chief County
25 Assessment Officer with a signed statement from the applicant's
26 physician stating the nature and extent of the condition, and

1 that, in the physician's opinion, the condition was so severe
2 that it rendered the applicant incapable of filing the
3 application in a timely manner.

4 In counties having less than 3,000,000 inhabitants, if an
5 applicant was denied an exemption in taxable year 1994 and the
6 denial occurred due to an error on the part of an assessment
7 official, or his or her agent or employee, then beginning in
8 taxable year 1997 the applicant's base year, for purposes of
9 determining the amount of the exemption, shall be 1993 rather
10 than 1994. In addition, in taxable year 1997, the applicant's
11 exemption shall also include an amount equal to (i) the amount
12 of any exemption denied to the applicant in taxable year 1995
13 as a result of using 1994, rather than 1993, as the base year,
14 (ii) the amount of any exemption denied to the applicant in
15 taxable year 1996 as a result of using 1994, rather than 1993,
16 as the base year, and (iii) the amount of the exemption
17 erroneously denied for taxable year 1994.

18 For purposes of this Section, a person who will be 65 years
19 of age during the current taxable year shall be eligible to
20 apply for the homestead exemption during that taxable year.
21 Application shall be made during the application period in
22 effect for the county of his or her residence.

23 The Chief County Assessment Officer may determine the
24 eligibility of a life care facility that qualifies as a
25 cooperative to receive the benefits provided by this Section by
26 use of an affidavit, application, visual inspection,

1 questionnaire, or other reasonable method in order to insure
2 that the tax savings resulting from the exemption are credited
3 by the management firm to the apportioned tax liability of each
4 qualifying resident. The Chief County Assessment Officer may
5 request reasonable proof that the management firm has so
6 credited that exemption.

7 Except as provided in this Section, all information
8 received by the chief county assessment officer or the
9 Department from applications filed under this Section, or from
10 any investigation conducted under the provisions of this
11 Section, shall be confidential, except for official purposes or
12 pursuant to official procedures for collection of any State or
13 local tax or enforcement of any civil or criminal penalty or
14 sanction imposed by this Act or by any statute or ordinance
15 imposing a State or local tax. Any person who divulges any such
16 information in any manner, except in accordance with a proper
17 judicial order, is guilty of a Class A misdemeanor.

18 Nothing contained in this Section shall prevent the
19 Director or chief county assessment officer from publishing or
20 making available reasonable statistics concerning the
21 operation of the exemption contained in this Section in which
22 the contents of claims are grouped into aggregates in such a
23 way that information contained in any individual claim shall
24 not be disclosed.

25 (d) Each Chief County Assessment Officer shall annually
26 publish a notice of availability of the exemption provided

1 under this Section. The notice shall be published at least 60
2 days but no more than 75 days prior to the date on which the
3 application must be submitted to the Chief County Assessment
4 Officer of the county in which the property is located. The
5 notice shall appear in a newspaper of general circulation in
6 the county.

7 Notwithstanding Sections 6 and 8 of the State Mandates Act,
8 no reimbursement by the State is required for the
9 implementation of any mandate created by this Section.

10 (Source: P.A. 96-339, eff. 7-1-10; 96-355, eff. 1-1-10;
11 96-1000, eff. 7-2-10; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12;
12 revised 9-12-11.)

13 (35 ILCS 200/15-175)

14 Sec. 15-175. General homestead exemption. Except as
15 provided in Sections 15-176 and 15-177, homestead property is
16 entitled to an annual homestead exemption limited, except as
17 described here with relation to cooperatives, to a reduction in
18 the equalized assessed value of homestead property equal to the
19 increase in equalized assessed value for the current assessment
20 year above the equalized assessed value of the property for
21 1977, up to the maximum reduction set forth below. If however,
22 the 1977 equalized assessed value upon which taxes were paid is
23 subsequently determined by local assessing officials, the
24 Property Tax Appeal Board, or a court to have been excessive,
25 the equalized assessed value which should have been placed on

1 the property for 1977 shall be used to determine the amount of
2 the exemption.

3 Except as provided in Section 15-176, the maximum reduction
4 before taxable year 2004 shall be \$4,500 in counties with
5 3,000,000 or more inhabitants and \$3,500 in all other counties.
6 Except as provided in Sections 15-176 and 15-177, for taxable
7 years 2004 through 2007, the maximum reduction shall be \$5,000,
8 for taxable year 2008, the maximum reduction is \$5,500, and,
9 for taxable years 2009 and thereafter, the maximum reduction is
10 \$6,000 in all counties. If a county has elected to subject
11 itself to the provisions of Section 15-176 as provided in
12 subsection (k) of that Section, then, for the first taxable
13 year only after the provisions of Section 15-176 no longer
14 apply, for owners who, for the taxable year, have not been
15 granted a senior citizens assessment freeze homestead
16 exemption under Section 15-172 or a long-time occupant
17 homestead exemption under Section 15-177, there shall be an
18 additional exemption of \$5,000 for owners with a household
19 income of \$30,000 or less.

20 In counties with fewer than 3,000,000 inhabitants, if,
21 based on the most recent assessment, the equalized assessed
22 value of the homestead property for the current assessment year
23 is greater than the equalized assessed value of the property
24 for 1977, the owner of the property shall automatically receive
25 the exemption granted under this Section in an amount equal to
26 the increase over the 1977 assessment up to the maximum

1 reduction set forth in this Section.

2 If in any assessment year beginning with the 2000
3 assessment year, homestead property has a pro-rata valuation
4 under Section 9-180 resulting in an increase in the assessed
5 valuation, a reduction in equalized assessed valuation equal to
6 the increase in equalized assessed value of the property for
7 the year of the pro-rata valuation above the equalized assessed
8 value of the property for 1977 shall be applied to the property
9 on a proportionate basis for the period the property qualified
10 as homestead property during the assessment year. The maximum
11 proportionate homestead exemption shall not exceed the maximum
12 homestead exemption allowed in the county under this Section
13 divided by 365 and multiplied by the number of days the
14 property qualified as homestead property.

15 "Homestead property" under this Section includes
16 residential property that is occupied by its owner or owners as
17 his or their principal dwelling place, or that is a leasehold
18 interest on which a single family residence is situated, which
19 is occupied as a residence by a person who has an ownership
20 interest therein, legal or equitable or as a lessee, and on
21 which the person is liable for the payment of property taxes.
22 For land improved with an apartment building owned and operated
23 as a cooperative or a building which is a life care facility as
24 defined in Section 15-170 and considered to be a cooperative
25 under Section 15-170, the maximum reduction from the equalized
26 assessed value shall be limited to the increase in the value

1 above the equalized assessed value of the property for 1977, up
2 to the maximum reduction set forth above, multiplied by the
3 number of apartments or units occupied by a person or persons
4 who is liable, by contract with the owner or owners of record,
5 for paying property taxes on the property and is an owner of
6 record of a legal or equitable interest in the cooperative
7 apartment building, other than a leasehold interest. For
8 purposes of this Section, the term "life care facility" has the
9 meaning stated in Section 15-170.

10 "Household", as used in this Section, means the owner, the
11 spouse of the owner, and all persons using the residence of the
12 owner as their principal place of residence.

13 "Household income", as used in this Section, means the
14 combined income of the members of a household for the calendar
15 year preceding the taxable year.

16 "Income", as used in this Section, has the same meaning as
17 provided in Section 3.07 of the Senior Citizens and Disabled
18 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act,
19 except that "income" does not include veteran's benefits.

20 In a cooperative where a homestead exemption has been
21 granted, the cooperative association or its management firm
22 shall credit the savings resulting from that exemption only to
23 the apportioned tax liability of the owner who qualified for
24 the exemption. Any person who willfully refuses to so credit
25 the savings shall be guilty of a Class B misdemeanor.

26 Where married persons maintain and reside in separate

1 residences qualifying as homestead property, each residence
2 shall receive 50% of the total reduction in equalized assessed
3 valuation provided by this Section.

4 In all counties, the assessor or chief county assessment
5 officer may determine the eligibility of residential property
6 to receive the homestead exemption and the amount of the
7 exemption by application, visual inspection, questionnaire or
8 other reasonable methods. The determination shall be made in
9 accordance with guidelines established by the Department,
10 provided that the taxpayer applying for an additional general
11 exemption under this Section shall submit to the chief county
12 assessment officer an application with an affidavit of the
13 applicant's total household income, age, marital status (and,
14 if married, the name and address of the applicant's spouse, if
15 known), and principal dwelling place of members of the
16 household on January 1 of the taxable year. The Department
17 shall issue guidelines establishing a method for verifying the
18 accuracy of the affidavits filed by applicants under this
19 paragraph. The applications shall be clearly marked as
20 applications for the Additional General Homestead Exemption.

21 In counties with fewer than 3,000,000 inhabitants, in the
22 event of a sale of homestead property the homestead exemption
23 shall remain in effect for the remainder of the assessment year
24 of the sale. The assessor or chief county assessment officer
25 may require the new owner of the property to apply for the
26 homestead exemption for the following assessment year.

1 Notwithstanding Sections 6 and 8 of the State Mandates Act,
2 no reimbursement by the State is required for the
3 implementation of any mandate created by this Section.

4 (Source: P.A. 95-644, eff. 10-12-07.)

5 (35 ILCS 200/20-15)

6 Sec. 20-15. Information on bill or separate statement.
7 There shall be printed on each bill, or on a separate slip
8 which shall be mailed with the bill:

9 (a) a statement itemizing the rate at which taxes have
10 been extended for each of the taxing districts in the
11 county in whose district the property is located, and in
12 those counties utilizing electronic data processing
13 equipment the dollar amount of tax due from the person
14 assessed allocable to each of those taxing districts,
15 including a separate statement of the dollar amount of tax
16 due which is allocable to a tax levied under the Illinois
17 Local Library Act or to any other tax levied by a
18 municipality or township for public library purposes,

19 (b) a separate statement for each of the taxing
20 districts of the dollar amount of tax due which is
21 allocable to a tax levied under the Illinois Pension Code
22 or to any other tax levied by a municipality or township
23 for public pension or retirement purposes,

24 (c) the total tax rate,

25 (d) the total amount of tax due, and

1 (e) the amount by which the total tax and the tax
2 allocable to each taxing district differs from the
3 taxpayer's last prior tax bill.

4 The county treasurer shall ensure that only those taxing
5 districts in which a parcel of property is located shall be
6 listed on the bill for that property.

7 In all counties the statement shall also provide:

8 (1) the property index number or other suitable
9 description,

10 (2) the assessment of the property,

11 (3) the equalization factors imposed by the county and
12 by the Department, and

13 (4) the equalized assessment resulting from the
14 application of the equalization factors to the basic
15 assessment.

16 In all counties which do not classify property for purposes
17 of taxation, for property on which a single family residence is
18 situated the statement shall also include a statement to
19 reflect the fair cash value determined for the property. In all
20 counties which classify property for purposes of taxation in
21 accordance with Section 4 of Article IX of the Illinois
22 Constitution, for parcels of residential property in the lowest
23 assessment classification the statement shall also include a
24 statement to reflect the fair cash value determined for the
25 property.

26 In all counties, the statement must include information

1 that certain taxpayers may be eligible for tax exemptions,
2 abatements, and other assistance programs and that, for more
3 information, taxpayers should consult with the office of their
4 township or county assessor and with the Illinois Department of
5 Revenue.

6 In all counties, the statement shall include information
7 that certain taxpayers may be eligible for the Senior Citizens
8 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
9 ~~Assistance~~ Act and that applications are available from the
10 Illinois Department on Aging.

11 In counties which use the estimated or accelerated billing
12 methods, these statements shall only be provided with the final
13 installment of taxes due. The provisions of this Section create
14 a mandatory statutory duty. They are not merely directory or
15 discretionary. The failure or neglect of the collector to mail
16 the bill, or the failure of the taxpayer to receive the bill,
17 shall not affect the validity of any tax, or the liability for
18 the payment of any tax.

19 (Source: P.A. 95-644, eff. 10-12-07.)

20 (35 ILCS 200/21-27)

21 Sec. 21-27. Waiver of interest penalty.

22 (a) On the recommendation of the county treasurer, the
23 county board may adopt a resolution under which an interest
24 penalty for the delinquent payment of taxes for any year that
25 otherwise would be imposed under Section 21-15, 21-20, or 21-25

1 shall be waived in the case of any person who meets all of the
2 following criteria:

3 (1) The person is determined eligible for a grant under
4 the Senior Citizens and Disabled Persons Property Tax
5 Relief ~~and Pharmaceutical Assistance~~ Act with respect to
6 the taxes for that year.

7 (2) The person requests, in writing, on a form approved
8 by the county treasurer, a waiver of the interest penalty,
9 and the request is filed with the county treasurer on or
10 before the first day of the month that an installment of
11 taxes is due.

12 (3) The person pays the installment of taxes due, in
13 full, on or before the third day of the month that the
14 installment is due.

15 (4) The county treasurer approves the request for a
16 waiver.

17 (b) With respect to property that qualifies as a brownfield
18 site under Section 58.2 of the Environmental Protection Act,
19 the county board, upon the recommendation of the county
20 treasurer, may adopt a resolution to waive an interest penalty
21 for the delinquent payment of taxes for any year that otherwise
22 would be imposed under Section 21-15, 21-20, or 21-25 if all of
23 the following criteria are met:

24 (1) the property has delinquent taxes and an
25 outstanding interest penalty and the amount of that
26 interest penalty is so large as to, possibly, result in all

1 of the taxes becoming uncollectible;

2 (2) the property is part of a redevelopment plan of a
3 unit of local government and that unit of local government
4 does not oppose the waiver of the interest penalty;

5 (3) the redevelopment of the property will benefit the
6 public interest by remediating the brownfield
7 contamination;

8 (4) the taxpayer delivers to the county treasurer (i) a
9 written request for a waiver of the interest penalty, on a
10 form approved by the county treasurer, and (ii) a copy of
11 the redevelopment plan for the property;

12 (5) the taxpayer pays, in full, the amount of up to the
13 amount of the first 2 installments of taxes due, to be held
14 in escrow pending the approval of the waiver, and enters
15 into an agreement with the county treasurer setting forth a
16 schedule for the payment of any remaining taxes due; and

17 (6) the county treasurer approves the request for a
18 waiver.

19 (Source: P.A. 97-655, eff. 1-13-12.)

20 Section 925. The Mobile Home Local Services Tax Act is
21 amended by changing Section 7 as follows:

22 (35 ILCS 515/7) (from Ch. 120, par. 1207)

23 Sec. 7. The local services tax for owners of mobile homes
24 who (a) are actually residing in such mobile homes, (b) hold

1 title to such mobile home as provided in the Illinois Vehicle
2 Code, and (c) are 65 years of age or older or are disabled
3 persons within the meaning of Section 3.14 of the "Senior
4 Citizens and Disabled Persons Property Tax Relief ~~and~~
5 ~~Pharmaceutical Assistance Act~~" on the annual billing date shall
6 be reduced to 80 percent of the tax provided for in Section 3
7 of this Act. Proof that a claimant has been issued an Illinois
8 Disabled Person Identification Card stating that the claimant
9 is under a Class 2 disability, as provided in Section 4A of the
10 Illinois Identification Card Act, shall constitute proof that
11 the person thereon named is a disabled person within the
12 meaning of this Act. An application for reduction of the tax
13 shall be filed with the county clerk by the individuals who are
14 entitled to the reduction. If the application is filed after
15 May 1, the reduction in tax shall begin with the next annual
16 bill. Application for the reduction in tax shall be done by
17 submitting proof that the applicant has been issued an Illinois
18 Disabled Person Identification Card designating the
19 applicant's disability as a Class 2 disability, or by affidavit
20 in substantially the following form:

21 APPLICATION FOR REDUCTION OF MOBILE HOME LOCAL SERVICES TAX

22 I hereby make application for a reduction to 80% of the
23 total tax imposed under "An Act to provide for a local services
24 tax on mobile homes".

25 (1) Senior Citizens

26 (a) I actually reside in the mobile home

1 (b) I hold title to the mobile home as provided in the
2 Illinois Vehicle Code

3 (c) I reached the age of 65 on or before either January 1
4 (or July 1) of the year in which this statement is filed. My
5 date of birth is: ...

6 (2) Disabled Persons

7 (a) I actually reside in the mobile home...

8 (b) I hold title to the mobile home as provided in the
9 Illinois Vehicle Code

10 (c) I was totally disabled on ... and have remained
11 disabled until the date of this application. My Social
12 Security, Veterans, Railroad or Civil Service Total Disability
13 Claim Number is ... The undersigned declares under the penalty
14 of perjury that the above statements are true and correct.

15 Dated (insert date).

16

17 Signature of owner

18

19 (Address)

20

21 (City) (State) (Zip)

22 Approved by:

23

24 (Assessor)

25 This application shall be accompanied by a copy of the

1 applicant's most recent application filed with the Illinois
2 Department on Aging under the Senior Citizens and Disabled
3 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.
4 (Source: P.A. 96-804, eff. 1-1-10.)

5 Section 930. The Metropolitan Transit Authority Act is
6 amended by changing Sections 51 and 52 as follows:

7 (70 ILCS 3605/51)

8 Sec. 51. Free services; eligibility.

9 (a) Notwithstanding any law to the contrary, no later than
10 60 days following the effective date of this amendatory Act of
11 the 95th General Assembly and until subsection (b) is
12 implemented, any fixed route public transportation services
13 provided by, or under grant or purchase of service contracts
14 of, the Board shall be provided without charge to all senior
15 citizens of the Metropolitan Region (as such term is defined in
16 70 ILCS 3615/1.03) aged 65 and older, under such conditions as
17 shall be prescribed by the Board.

18 (b) Notwithstanding any law to the contrary, no later than
19 180 days following the effective date of this amendatory Act of
20 the 96th General Assembly, any fixed route public
21 transportation services provided by, or under grant or purchase
22 of service contracts of, the Board shall be provided without
23 charge to senior citizens aged 65 and older who meet the income
24 eligibility limitation set forth in subsection (a-5) of Section

1 4 of the Senior Citizens and Disabled Persons Property Tax
2 Relief ~~and Pharmaceutical Assistance~~ Act, under such
3 conditions as shall be prescribed by the Board. The Department
4 on Aging shall furnish all information reasonably necessary to
5 determine eligibility, including updated lists of individuals
6 who are eligible for services without charge under this
7 Section. Nothing in this Section shall relieve the Board from
8 providing reduced fares as may be required by federal law.

9 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

10 (70 ILCS 3605/52)

11 Sec. 52. Transit services for disabled individuals.
12 Notwithstanding any law to the contrary, no later than 60 days
13 following the effective date of this amendatory Act of the 95th
14 General Assembly, all fixed route public transportation
15 services provided by, or under grant or purchase of service
16 contract of, the Board shall be provided without charge to all
17 disabled persons who meet the income eligibility limitation set
18 forth in subsection (a-5) of Section 4 of the Senior Citizens
19 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
20 ~~Assistance~~ Act, under such procedures as shall be prescribed by
21 the Board. The Department on Aging shall furnish all
22 information reasonably necessary to determine eligibility,
23 including updated lists of individuals who are eligible for
24 services without charge under this Section.

25 (Source: P.A. 95-906, eff. 8-26-08.)

1 Section 935. The Local Mass Transit District Act is amended
2 by changing Sections 8.6 and 8.7 as follows:

3 (70 ILCS 3610/8.6)

4 Sec. 8.6. Free services; eligibility.

5 (a) Notwithstanding any law to the contrary, no later than
6 60 days following the effective date of this amendatory Act of
7 the 95th General Assembly and until subsection (b) is
8 implemented, any fixed route public transportation services
9 provided by, or under grant or purchase of service contracts
10 of, every District shall be provided without charge to all
11 senior citizens of the District aged 65 and older, under such
12 conditions as shall be prescribed by the District.

13 (b) Notwithstanding any law to the contrary, no later than
14 180 days following the effective date of this amendatory Act of
15 the 96th General Assembly, any fixed route public
16 transportation services provided by, or under grant or purchase
17 of service contracts of, every District shall be provided
18 without charge to senior citizens aged 65 and older who meet
19 the income eligibility limitation set forth in subsection (a-5)
20 of Section 4 of the Senior Citizens and Disabled Persons
21 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under
22 such conditions as shall be prescribed by the District. The
23 Department on Aging shall furnish all information reasonably
24 necessary to determine eligibility, including updated lists of

1 individuals who are eligible for services without charge under
2 this Section. Nothing in this Section shall relieve the
3 District from providing reduced fares as may be required by
4 federal law.

5 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

6 (70 ILCS 3610/8.7)

7 Sec. 8.7. Transit services for disabled individuals.
8 Notwithstanding any law to the contrary, no later than 60 days
9 following the effective date of this amendatory Act of the 95th
10 General Assembly, all fixed route public transportation
11 services provided by, or under grant or purchase of service
12 contract of, any District shall be provided without charge to
13 all disabled persons who meet the income eligibility limitation
14 set forth in subsection (a-5) of Section 4 of the Senior
15 Citizens and Disabled Persons Property Tax Relief ~~and~~
16 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
17 be prescribed by the District. The Department on Aging shall
18 furnish all information reasonably necessary to determine
19 eligibility, including updated lists of individuals who are
20 eligible for services without charge under this Section.

21 (Source: P.A. 95-906, eff. 8-26-08.)

22 Section 940. The Regional Transportation Authority Act is
23 amended by changing Sections 3A.15, 3A.16, 3B.14, and 3B.15 as
24 follows:

1 (70 ILCS 3615/3A.15)

2 Sec. 3A.15. Free services; eligibility.

3 (a) Notwithstanding any law to the contrary, no later than
4 60 days following the effective date of this amendatory Act of
5 the 95th General Assembly and until subsection (b) is
6 implemented, any fixed route public transportation services
7 provided by, or under grant or purchase of service contracts
8 of, the Suburban Bus Board shall be provided without charge to
9 all senior citizens of the Metropolitan Region aged 65 and
10 older, under such conditions as shall be prescribed by the
11 Suburban Bus Board.

12 (b) Notwithstanding any law to the contrary, no later than
13 180 days following the effective date of this amendatory Act of
14 the 96th General Assembly, any fixed route public
15 transportation services provided by, or under grant or purchase
16 of service contracts of, the Suburban Bus Board shall be
17 provided without charge to senior citizens aged 65 and older
18 who meet the income eligibility limitation set forth in
19 subsection (a-5) of Section 4 of the Senior Citizens and
20 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
21 ~~Assistance~~ Act, under such conditions as shall be prescribed by
22 the Suburban Bus Board. The Department on Aging shall furnish
23 all information reasonably necessary to determine eligibility,
24 including updated lists of individuals who are eligible for
25 services without charge under this Section. Nothing in this

1 Section shall relieve the Suburban Bus Board from providing
2 reduced fares as may be required by federal law.

3 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

4 (70 ILCS 3615/3A.16)

5 Sec. 3A.16. Transit services for disabled individuals.
6 Notwithstanding any law to the contrary, no later than 60 days
7 following the effective date of this amendatory Act of the 95th
8 General Assembly, all fixed route public transportation
9 services provided by, or under grant or purchase of service
10 contract of, the Suburban Bus Board shall be provided without
11 charge to all disabled persons who meet the income eligibility
12 limitation set forth in subsection (a-5) of Section 4 of the
13 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
14 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
15 be prescribed by the Board. The Department on Aging shall
16 furnish all information reasonably necessary to determine
17 eligibility, including updated lists of individuals who are
18 eligible for services without charge under this Section.

19 (Source: P.A. 95-906, eff. 8-26-08.)

20 (70 ILCS 3615/3B.14)

21 Sec. 3B.14. Free services; eligibility.

22 (a) Notwithstanding any law to the contrary, no later than
23 60 days following the effective date of this amendatory Act of
24 the 95th General Assembly and until subsection (b) is

1 implemented, any fixed route public transportation services
2 provided by, or under grant or purchase of service contracts
3 of, the Commuter Rail Board shall be provided without charge to
4 all senior citizens of the Metropolitan Region aged 65 and
5 older, under such conditions as shall be prescribed by the
6 Commuter Rail Board.

7 (b) Notwithstanding any law to the contrary, no later than
8 180 days following the effective date of this amendatory Act of
9 the 96th General Assembly, any fixed route public
10 transportation services provided by, or under grant or purchase
11 of service contracts of, the Commuter Rail Board shall be
12 provided without charge to senior citizens aged 65 and older
13 who meet the income eligibility limitation set forth in
14 subsection (a-5) of Section 4 of the Senior Citizens and
15 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
16 ~~Assistance~~ Act, under such conditions as shall be prescribed by
17 the Commuter Rail Board. The Department on Aging shall furnish
18 all information reasonably necessary to determine eligibility,
19 including updated lists of individuals who are eligible for
20 services without charge under this Section. Nothing in this
21 Section shall relieve the Commuter Rail Board from providing
22 reduced fares as may be required by federal law.

23 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

24 (70 ILCS 3615/3B.15)

25 Sec. 3B.15. Transit services for disabled individuals.

1 Notwithstanding any law to the contrary, no later than 60 days
2 following the effective date of this amendatory Act of the 95th
3 General Assembly, all fixed route public transportation
4 services provided by, or under grant or purchase of service
5 contract of, the Commuter Rail Board shall be provided without
6 charge to all disabled persons who meet the income eligibility
7 limitation set forth in subsection (a-5) of Section 4 of the
8 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
9 ~~Pharmaceutical Assistance Act~~, under such procedures as shall
10 be prescribed by the Board. The Department on Aging shall
11 furnish all information reasonably necessary to determine
12 eligibility, including updated lists of individuals who are
13 eligible for services without charge under this Section.

14 (Source: P.A. 95-906, eff. 8-26-08.)

15 Section 945. The Senior Citizen Courses Act is amended by
16 changing Section 1 as follows:

17 (110 ILCS 990/1) (from Ch. 144, par. 1801)

18 Sec. 1. Definitions. For the purposes of this Act:

19 (a) "Public institutions of higher education" means the
20 University of Illinois, Southern Illinois University, Chicago
21 State University, Eastern Illinois University, Governors State
22 University, Illinois State University, Northeastern Illinois
23 University, Northern Illinois University, Western Illinois
24 University, and the public community colleges subject to the

1 "Public Community College Act".

2 (b) "Credit Course" means any program of study for which
3 public institutions of higher education award credit hours.

4 (c) "Senior citizen" means any person 65 years or older
5 whose annual household income is less than the threshold amount
6 provided in Section 4 of the "Senior Citizens and Disabled
7 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~
8 Act", approved July 17, 1972, as amended.

9 (Source: P.A. 89-4, eff. 1-1-96.)

10 Section 950. The Citizens Utility Board Act is amended by
11 changing Section 9 as follows:

12 (220 ILCS 10/9) (from Ch. 111 2/3, par. 909)

13 Sec. 9. Mailing procedure.

14 (1) As used in this Section:

15 (a) "Enclosure" means a card, leaflet, envelope or
16 combination thereof furnished by the corporation under
17 this Section.

18 (b) "Mailing" means any communication by a State
19 agency, other than a mailing made under the Senior Citizens
20 and Disabled Persons Property Tax Relief ~~and~~
21 ~~Pharmaceutical Assistance~~ Act, that is sent through the
22 United States Postal Service to more than 50,000 persons
23 within a 12-month period.

24 (c) "State agency" means any officer, department,

1 board, commission, institution or entity of the executive
2 or legislative branches of State government.

3 (2) To accomplish its powers and duties under Section 5
4 this Act, the corporation, subject to the following
5 limitations, may prepare and furnish to any State agency an
6 enclosure to be included with a mailing by that agency.

7 (a) A State agency furnished with an enclosure shall
8 include the enclosure within the mailing designated by the
9 corporation.

10 (b) An enclosure furnished by the corporation under
11 this Section shall be provided to the State agency a
12 reasonable period of time in advance of the mailing.

13 (c) An enclosure furnished by the corporation under
14 this Section shall be limited to informing the reader of
15 the purpose, nature and activities of the corporation as
16 set forth in this Act and informing the reader that it may
17 become a member in the corporation, maintain membership in
18 the corporation and contribute money to the corporation
19 directly.

20 (d) Prior to furnishing an enclosure to the State
21 agency, the corporation shall seek and obtain approval of
22 the content of the enclosure from the Illinois Commerce
23 Commission. The Commission shall approve the enclosure if
24 it determines that the enclosure (i) is not false or
25 misleading and (ii) satisfies the requirements of this Act.
26 The Commission shall be deemed to have approved the

1 enclosure unless it disapproves the enclosure within 14
2 days from the date of receipt.

3 (3) The corporation shall reimburse each State agency for
4 all reasonable incremental costs incurred by the State agency
5 in complying with this Section above the agency's normal
6 mailing and handling costs, provided that:

7 (a) The State agency shall first furnish the
8 corporation with an itemized accounting of such additional
9 cost; and

10 (b) The corporation shall not be required to reimburse
11 the State agency for postage costs if the weight of the
12 corporation's enclosure does not exceed .35 ounce
13 avoirdupois. If the corporation's enclosure exceeds that
14 weight, then it shall only be required to reimburse the
15 State agency for postage cost over and above what the
16 agency's postage cost would have been had the enclosure
17 weighed only .35 ounce avoirdupois.

18 (Source: P.A. 96-804, eff. 1-1-10.)

19 Section 955. The Illinois Public Aid Code is amended by
20 changing Sections 3-5, 4-1.6, 4-2, 6-1.2, 6-2, and 12-9 as
21 follows:

22 (305 ILCS 5/3-5) (from Ch. 23, par. 3-5)

23 Sec. 3-5. Amount of aid. The amount and nature of financial
24 aid granted to or in behalf of aged, blind, or disabled persons

1 shall be determined in accordance with the standards, grant
2 amounts, rules and regulations of the Illinois Department. Due
3 regard shall be given to the requirements and conditions
4 existing in each case, and to the amount of property owned and
5 the income, money contributions, and other support, and
6 resources received or obtainable by the person, from whatever
7 source. However, the amount and nature of any financial aid is
8 not affected by the payment of any grant under the "Senior
9 Citizens and Disabled Persons Property Tax Relief ~~and~~
10 ~~Pharmaceutical Assistance Act~~" or any distributions or items of
11 income described under subparagraph (X) of paragraph (2) of
12 subsection (a) of Section 203 of the Illinois Income Tax Act.
13 The aid shall be sufficient, when added to all other income,
14 money contributions and support, to provide the person with a
15 grant in the amount established by Department regulation for
16 such a person, based upon standards providing a livelihood
17 compatible with health and well-being. Financial aid under this
18 Article granted to persons who have been found ineligible for
19 Supplemental Security Income (SSI) due to expiration of the
20 period of eligibility for refugees and asylees pursuant to 8
21 U.S.C. 1612(a)(2) shall not exceed \$500 per month.

22 (Source: P.A. 93-741, eff. 7-15-04.)

23 (305 ILCS 5/4-1.6) (from Ch. 23, par. 4-1.6)

24 Sec. 4-1.6. Need. Income available to the family as defined
25 by the Illinois Department by rule, or to the child in the case

1 of a child removed from his or her home, when added to
2 contributions in money, substance or services from other
3 sources, including income available from parents absent from
4 the home or from a stepparent, contributions made for the
5 benefit of the parent or other persons necessary to provide
6 care and supervision to the child, and contributions from
7 legally responsible relatives, must be equal to or less than
8 the grant amount established by Department regulation for such
9 a person. For purposes of eligibility for aid under this
10 Article, the Department shall disregard all earned income
11 between the grant amount and 50% of the Federal Poverty Level.

12 In considering income to be taken into account,
13 consideration shall be given to any expenses reasonably
14 attributable to the earning of such income. Three-fourths of
15 the earned income of a household eligible for aid under this
16 Article shall be disregarded when determining the level of
17 assistance for which a household is eligible. The Illinois
18 Department may also permit all or any portion of earned or
19 other income to be set aside for the future identifiable needs
20 of a child. The Illinois Department may provide by rule and
21 regulation for the exemptions thus permitted or required. The
22 eligibility of any applicant for or recipient of public aid
23 under this Article is not affected by the payment of any grant
24 under the "Senior Citizens and Disabled Persons Property Tax
25 Relief ~~and Pharmaceutical Assistance~~ Act" or any distributions
26 or items of income described under subparagraph (X) of

1 paragraph (2) of subsection (a) of Section 203 of the Illinois
2 Income Tax Act.

3 The Illinois Department may, by rule, set forth criteria
4 under which an assistance unit is ineligible for cash
5 assistance under this Article for a specified number of months
6 due to the receipt of a lump sum payment.

7 (Source: P.A. 96-866, eff. 7-1-10.)

8 (305 ILCS 5/4-2) (from Ch. 23, par. 4-2)

9 Sec. 4-2. Amount of aid.

10 (a) The amount and nature of financial aid shall be
11 determined in accordance with the grant amounts, rules and
12 regulations of the Illinois Department. Due regard shall be
13 given to the self-sufficiency requirements of the family and to
14 the income, money contributions and other support and resources
15 available, from whatever source. However, the amount and nature
16 of any financial aid is not affected by the payment of any
17 grant under the "Senior Citizens and Disabled Persons Property
18 Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any
19 distributions or items of income described under subparagraph
20 (X) of paragraph (2) of subsection (a) of Section 203 of the
21 Illinois Income Tax Act. The aid shall be sufficient, when
22 added to all other income, money contributions and support to
23 provide the family with a grant in the amount established by
24 Department regulation.

25 Subject to appropriation, beginning on July 1, 2008, the

1 Department of Human Services shall increase TANF grant amounts
2 in effect on June 30, 2008 by 15%. The Department is authorized
3 to administer this increase but may not otherwise adopt any
4 rule to implement this increase.

5 (b) The Illinois Department may conduct special projects,
6 which may be known as Grant Diversion Projects, under which
7 recipients of financial aid under this Article are placed in
8 jobs and their grants are diverted to the employer who in turn
9 makes payments to the recipients in the form of salary or other
10 employment benefits. The Illinois Department shall by rule
11 specify the terms and conditions of such Grant Diversion
12 Projects. Such projects shall take into consideration and be
13 coordinated with the programs administered under the Illinois
14 Emergency Employment Development Act.

15 (c) The amount and nature of the financial aid for a child
16 requiring care outside his own home shall be determined in
17 accordance with the rules and regulations of the Illinois
18 Department, with due regard to the needs and requirements of
19 the child in the foster home or institution in which he has
20 been placed.

21 (d) If the Department establishes grants for family units
22 consisting exclusively of a pregnant woman with no dependent
23 child or including her husband if living with her, the grant
24 amount for such a unit shall be equal to the grant amount for
25 an assistance unit consisting of one adult, or 2 persons if the
26 husband is included. Other than as herein described, an unborn

1 child shall not be counted in determining the size of an
2 assistance unit or for calculating grants.

3 Payments for basic maintenance requirements of a child or
4 children and the relative with whom the child or children are
5 living shall be prescribed, by rule, by the Illinois
6 Department.

7 Grants under this Article shall not be supplemented by
8 General Assistance provided under Article VI.

9 (e) Grants shall be paid to the parent or other person with
10 whom the child or children are living, except for such amount
11 as is paid in behalf of the child or his parent or other
12 relative to other persons or agencies pursuant to this Code or
13 the rules and regulations of the Illinois Department.

14 (f) Subject to subsection (f-5), an assistance unit,
15 receiving financial aid under this Article or temporarily
16 ineligible to receive aid under this Article under a penalty
17 imposed by the Illinois Department for failure to comply with
18 the eligibility requirements or that voluntarily requests
19 termination of financial assistance under this Article and
20 becomes subsequently eligible for assistance within 9 months,
21 shall not receive any increase in the amount of aid solely on
22 account of the birth of a child; except that an increase is not
23 prohibited when the birth is (i) of a child of a pregnant woman
24 who became eligible for aid under this Article during the
25 pregnancy, or (ii) of a child born within 10 months after the
26 date of implementation of this subsection, or (iii) of a child

1 conceived after a family became ineligible for assistance due
2 to income or marriage and at least 3 months of ineligibility
3 expired before any reapplication for assistance. This
4 subsection does not, however, prevent a unit from receiving a
5 general increase in the amount of aid that is provided to all
6 recipients of aid under this Article.

7 The Illinois Department is authorized to transfer funds,
8 and shall use any budgetary savings attributable to not
9 increasing the grants due to the births of additional children,
10 to supplement existing funding for employment and training
11 services for recipients of aid under this Article IV. The
12 Illinois Department shall target, to the extent the
13 supplemental funding allows, employment and training services
14 to the families who do not receive a grant increase after the
15 birth of a child. In addition, the Illinois Department shall
16 provide, to the extent the supplemental funding allows, such
17 families with up to 24 months of transitional child care
18 pursuant to Illinois Department rules. All remaining
19 supplemental funds shall be used for employment and training
20 services or transitional child care support.

21 In making the transfers authorized by this subsection, the
22 Illinois Department shall first determine, pursuant to
23 regulations adopted by the Illinois Department for this
24 purpose, the amount of savings attributable to not increasing
25 the grants due to the births of additional children. Transfers
26 may be made from General Revenue Fund appropriations for

1 distributive purposes authorized by Article IV of this Code
2 only to General Revenue Fund appropriations for employability
3 development services including operating and administrative
4 costs and related distributive purposes under Article IXA of
5 this Code. The Director, with the approval of the Governor,
6 shall certify the amount and affected line item appropriations
7 to the State Comptroller.

8 Nothing in this subsection shall be construed to prohibit
9 the Illinois Department from using funds under this Article IV
10 to provide assistance in the form of vouchers that may be used
11 to pay for goods and services deemed by the Illinois
12 Department, by rule, as suitable for the care of the child such
13 as diapers, clothing, school supplies, and cribs.

14 (f-5) Subsection (f) shall not apply to affect the monthly
15 assistance amount of any family as a result of the birth of a
16 child on or after January 1, 2004. As resources permit after
17 January 1, 2004, the Department may cease applying subsection
18 (f) to limit assistance to families receiving assistance under
19 this Article on January 1, 2004, with respect to children born
20 prior to that date. In any event, subsection (f) shall be
21 completely inoperative on and after July 1, 2007.

22 (g) (Blank).

23 (h) Notwithstanding any other provision of this Code, the
24 Illinois Department is authorized to reduce payment levels used
25 to determine cash grants under this Article after December 31
26 of any fiscal year if the Illinois Department determines that

1 the caseload upon which the appropriations for the current
2 fiscal year are based have increased by more than 5% and the
3 appropriation is not sufficient to ensure that cash benefits
4 under this Article do not exceed the amounts appropriated for
5 those cash benefits. Reductions in payment levels may be
6 accomplished by emergency rule under Section 5-45 of the
7 Illinois Administrative Procedure Act, except that the
8 limitation on the number of emergency rules that may be adopted
9 in a 24-month period shall not apply and the provisions of
10 Sections 5-115 and 5-125 of the Illinois Administrative
11 Procedure Act shall not apply. Increases in payment levels
12 shall be accomplished only in accordance with Section 5-40 of
13 the Illinois Administrative Procedure Act. Before any rule to
14 increase payment levels promulgated under this Section shall
15 become effective, a joint resolution approving the rule must be
16 adopted by a roll call vote by a majority of the members
17 elected to each chamber of the General Assembly.

18 (Source: P.A. 95-744, eff. 7-18-08; 95-1055, eff. 4-10-09;
19 96-1000, eff. 7-2-10.)

20 (305 ILCS 5/6-1.2) (from Ch. 23, par. 6-1.2)

21 Sec. 6-1.2. Need. Income available to the person, when
22 added to contributions in money, substance, or services from
23 other sources, including contributions from legally
24 responsible relatives, must be insufficient to equal the grant
25 amount established by Department regulation (or by local

1 governmental unit in units which do not receive State funds)
2 for such a person.

3 In determining income to be taken into account:

4 (1) The first \$75 of earned income in income assistance
5 units comprised exclusively of one adult person shall be
6 disregarded, and for not more than 3 months in any 12
7 consecutive months that portion of earned income beyond the
8 first \$75 that is the difference between the standard of
9 assistance and the grant amount, shall be disregarded.

10 (2) For income assistance units not comprised
11 exclusively of one adult person, when authorized by rules
12 and regulations of the Illinois Department, a portion of
13 earned income, not to exceed the first \$25 a month plus 50%
14 of the next \$75, may be disregarded for the purpose of
15 stimulating and aiding rehabilitative effort and
16 self-support activity.

17 "Earned income" means money earned in self-employment or
18 wages, salary, or commission for personal services performed as
19 an employee. The eligibility of any applicant for or recipient
20 of public aid under this Article is not affected by the payment
21 of any grant under the "Senior Citizens and Disabled Persons
22 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act", any
23 refund or payment of the federal Earned Income Tax Credit, or
24 any distributions or items of income described under
25 subparagraph (X) of paragraph (2) of subsection (a) of Section
26 203 of the Illinois Income Tax Act.

1 (Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

2 (305 ILCS 5/6-2) (from Ch. 23, par. 6-2)

3 Sec. 6-2. Amount of aid. The amount and nature of General
4 Assistance for basic maintenance requirements shall be
5 determined in accordance with local budget standards for local
6 governmental units which do not receive State funds. For local
7 governmental units which do receive State funds, the amount and
8 nature of General Assistance for basic maintenance
9 requirements shall be determined in accordance with the
10 standards, rules and regulations of the Illinois Department.
11 However, the amount and nature of any financial aid is not
12 affected by the payment of any grant under the Senior Citizens
13 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
14 ~~Assistance~~ Act or any distributions or items of income
15 described under subparagraph (X) of paragraph (2) of subsection
16 (a) of Section 203 of the Illinois Income Tax Act. Due regard
17 shall be given to the requirements and the conditions existing
18 in each case, and to the income, money contributions and other
19 support and resources available, from whatever source. In local
20 governmental units which do not receive State funds, the grant
21 shall be sufficient when added to all other income, money
22 contributions and support in excess of any excluded income or
23 resources, to provide the person with a grant in the amount
24 established for such a person by the local governmental unit
25 based upon standards meeting basic maintenance requirements.

1 In local governmental units which do receive State funds, the
2 grant shall be sufficient when added to all other income, money
3 contributions and support in excess of any excluded income or
4 resources, to provide the person with a grant in the amount
5 established for such a person by Department regulation based
6 upon standards providing a livelihood compatible with health
7 and well-being, as directed by Section 12-4.11 of this Code.

8 The Illinois Department may conduct special projects,
9 which may be known as Grant Diversion Projects, under which
10 recipients of financial aid under this Article are placed in
11 jobs and their grants are diverted to the employer who in turn
12 makes payments to the recipients in the form of salary or other
13 employment benefits. The Illinois Department shall by rule
14 specify the terms and conditions of such Grant Diversion
15 Projects. Such projects shall take into consideration and be
16 coordinated with the programs administered under the Illinois
17 Emergency Employment Development Act.

18 The allowances provided under Article IX for recipients
19 participating in the training and rehabilitation programs
20 shall be in addition to such maximum payment.

21 Payments may also be made to provide persons receiving
22 basic maintenance support with necessary treatment, care and
23 supplies required because of illness or disability or with
24 acute medical treatment, care, and supplies. Payments for
25 necessary or acute medical care under this paragraph may be
26 made to or in behalf of the person. Obligations incurred for

1 such services but not paid for at the time of a recipient's
2 death may be paid, subject to the rules and regulations of the
3 Illinois Department, after the death of the recipient.

4 (Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

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

6 Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The
7 Public Aid Recoveries Trust Fund shall consist of (1)
8 recoveries by the Department of Healthcare and Family Services
9 (formerly Illinois Department of Public Aid) authorized by this
10 Code in respect to applicants or recipients under Articles III,
11 IV, V, and VI, including recoveries made by the Department of
12 Healthcare and Family Services (formerly Illinois Department
13 of Public Aid) from the estates of deceased recipients, (2)
14 recoveries made by the Department of Healthcare and Family
15 Services (formerly Illinois Department of Public Aid) in
16 respect to applicants and recipients under the Children's
17 Health Insurance Program Act, and the Covering ALL KIDS Health
18 Insurance Act, ~~and the Senior Citizens and Disabled Persons~~
19 ~~Property Tax Relief and Pharmaceutical Assistance Act,~~ (3)
20 federal funds received on behalf of and earned by State
21 universities and local governmental entities for services
22 provided to applicants or recipients covered under this Code,
23 the Children's Health Insurance Program Act, and the Covering
24 ALL KIDS Health Insurance Act, ~~and the Senior Citizens and~~
25 ~~Disabled Persons Property Tax Relief and Pharmaceutical~~

1 ~~Assistance Act,~~ (3.5) federal financial participation revenue
2 related to eligible disbursements made by the Department of
3 Healthcare and Family Services from appropriations required by
4 this Section, and (4) all other moneys received to the Fund,
5 including interest thereon. The Fund shall be held as a special
6 fund in the State Treasury.

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

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

20 The balance in this Fund on the first day of each calendar
21 quarter, after payment therefrom of any amounts reimbursable to
22 the federal government, and minus the amount reasonably
23 anticipated to be needed to make the disbursements during that
24 quarter authorized by this Section, shall be certified by the
25 Director of Healthcare and Family Services and transferred by
26 the State Comptroller to the Drug Rebate Fund or the Healthcare

1 Provider Relief Fund in the State Treasury, as appropriate,
2 within 30 days of the first day of each calendar quarter. The
3 Director of Healthcare and Family Services may certify and the
4 State Comptroller shall transfer to the Drug Rebate Fund
5 amounts on a more frequent basis.

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

10 (Source: P.A. 96-1100, eff. 1-1-11; 97-647, eff. 1-1-12.)

11 Section 960. The Senior Citizens Real Estate Tax Deferral
12 Act is amended by changing Sections 2 and 8 as follows:

13 (320 ILCS 30/2) (from Ch. 67 1/2, par. 452)

14 Sec. 2. Definitions. As used in this Act:

15 (a) "Taxpayer" means an individual whose household income
16 for the year is no greater than: (i) \$40,000 through tax year
17 2005; (ii) \$50,000 for tax years 2006 through 2011; and (iii)
18 \$55,000 for tax year 2012 and thereafter.

19 (b) "Tax deferred property" means the property upon which
20 real estate taxes are deferred under this Act.

21 (c) "Homestead" means the land and buildings thereon,
22 including a condominium or a dwelling unit in a multidwelling
23 building that is owned and operated as a cooperative, occupied
24 by the taxpayer as his residence or which are temporarily

1 unoccupied by the taxpayer because such taxpayer is temporarily
2 residing, for not more than 1 year, in a licensed facility as
3 defined in Section 1-113 of the Nursing Home Care Act.

4 (d) "Real estate taxes" or "taxes" means the taxes on real
5 property for which the taxpayer would be liable under the
6 Property Tax Code, including special service area taxes, and
7 special assessments on benefited real property for which the
8 taxpayer would be liable to a unit of local government.

9 (e) "Department" means the Department of Revenue.

10 (f) "Qualifying property" means a homestead which (a) the
11 taxpayer or the taxpayer and his spouse own in fee simple or
12 are purchasing in fee simple under a recorded instrument of
13 sale, (b) is not income-producing property, (c) is not subject
14 to a lien for unpaid real estate taxes when a claim under this
15 Act is filed, and (d) is not held in trust, other than an
16 Illinois land trust with the taxpayer identified as the sole
17 beneficiary, if the taxpayer is filing for the program for the
18 first time effective as of the January 1, 2011 assessment year
19 or tax year 2012 and thereafter.

20 (g) "Equity interest" means the current assessed valuation
21 of the qualified property times the fraction necessary to
22 convert that figure to full market value minus any outstanding
23 debts or liens on that property. In the case of qualifying
24 property not having a separate assessed valuation, the
25 appraised value as determined by a qualified real estate
26 appraiser shall be used instead of the current assessed

1 valuation.

2 (h) "Household income" has the meaning ascribed to that
3 term in the Senior Citizens and Disabled Persons Property Tax
4 Relief ~~and Pharmaceutical Assistance~~ Act.

5 (i) "Collector" means the county collector or, if the taxes
6 to be deferred are special assessments, an official designated
7 by a unit of local government to collect special assessments.

8 (Source: P.A. 97-481, eff. 8-22-11.)

9 (320 ILCS 30/8) (from Ch. 67 1/2, par. 458)

10 Sec. 8. Nothing in this Act (a) affects any provision of
11 any mortgage or other instrument relating to land requiring a
12 person to pay real estate taxes or (b) affects the eligibility
13 of any person to receive any grant pursuant to the "Senior
14 Citizens and Disabled Persons Property Tax Relief ~~and~~
15 ~~Pharmaceutical Assistance~~ Act".

16 (Source: P.A. 84-807; 84-832.)

17 Section 965. The Senior Pharmaceutical Assistance Act is
18 amended by changing Section 5 as follows:

19 (320 ILCS 50/5)

20 Sec. 5. Findings. The General Assembly finds:

21 (1) Senior citizens identify pharmaceutical assistance as
22 the single most critical factor to their health, well-being,
23 and continued independence.

1 (2) The State of Illinois currently operates 2
2 pharmaceutical assistance programs that benefit seniors: (i)
3 the program of pharmaceutical assistance under the Senior
4 Citizens and Disabled Persons Property Tax Relief ~~and~~
5 ~~Pharmaceutical Assistance~~ Act and (ii) the Aid to the Aged,
6 Blind, or Disabled program under the Illinois Public Aid Code.
7 The State has been given authority to establish a third
8 program, SeniorRx Care, through a federal Medicaid waiver.

9 (3) Each year, numerous pieces of legislation are filed
10 seeking to establish additional pharmaceutical assistance
11 benefits for seniors or to make changes to the existing
12 programs.

13 (4) Establishment of a pharmaceutical assistance review
14 committee will ensure proper coordination of benefits,
15 diminish the likelihood of duplicative benefits, and ensure
16 that the best interests of seniors are served.

17 (5) In addition to the State pharmaceutical assistance
18 programs, several private entities, such as drug manufacturers
19 and pharmacies, also offer prescription drug discount or
20 coverage programs.

21 (6) Many seniors are unaware of the myriad of public and
22 private programs available to them.

23 (7) Establishing a pharmaceutical clearinghouse with a
24 toll-free hot-line and local outreach workers will educate
25 seniors about the vast array of options available to them and
26 enable seniors to make an educated and informed choice that is

1 best for them.

2 (8) Estimates indicate that almost one-third of senior
3 citizens lack prescription drug coverage. The federal
4 government, states, and the pharmaceutical industry each have a
5 role in helping these uninsured seniors gain access to
6 life-saving medications.

7 (9) The State of Illinois has recognized its obligation to
8 assist Illinois' neediest seniors in purchasing prescription
9 medications, and it is now time for pharmaceutical
10 manufacturers to recognize their obligation to make their
11 medications affordable to seniors.

12 (Source: P.A. 92-594, eff. 6-27-02.)

13 Section 970. The Illinois Vehicle Code is amended by
14 changing Sections 3-609, 3-623, 3-626, 3-667, 3-683, 3-806.3,
15 and 11-1301.2 as follows:

16 (625 ILCS 5/3-609) (from Ch. 95 1/2, par. 3-609)

17 Sec. 3-609. Disabled Veterans' Plates. Any veteran may make
18 application for the registration of one motor vehicle of the
19 first division or one motor vehicle of the second division
20 weighing not more than 8,000 pounds to the Secretary of State
21 without the payment of any registration fee if (i) the veteran
22 holds proof of a service-connected disability from the United
23 States Department of Veterans Affairs and (ii) a licensed
24 physician, physician assistant, or advanced practice nurse has

1 certified in accordance with Section 3-616 that because of the
2 service-connected disability the veteran qualifies for
3 issuance of registration plates or decals to a person with
4 disabilities. The Secretary may, in his or her discretion,
5 allow the plates to be issued as vanity or personalized plates
6 in accordance with Section 3-405.1 of this Code. Registration
7 shall be for a multi-year period and may be issued staggered
8 registration.

9 Renewal of such registration must be accompanied with
10 documentation for eligibility of registration without fee
11 unless the applicant has a permanent qualifying disability, and
12 such registration plates may not be issued to any person not
13 eligible therefor.

14 The Illinois Department of Veterans' Affairs may assist in
15 providing the documentation of disability.

16 Commencing with the 2009 registration year, any person
17 eligible to receive license plates under this Section who has
18 been approved for benefits under the Senior Citizens and
19 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
20 ~~Assistance~~ Act, or who has claimed and received a grant under
21 that Act, shall pay a fee of \$24 instead of the fee otherwise
22 provided in this Code for passenger cars displaying standard
23 multi-year registration plates issued under Section 3-414.1,
24 for motor vehicles registered at 8,000 pounds or less under
25 Section 3-815(a), or for recreational vehicles registered at
26 8,000 pounds or less under Section 3-815(b), for a second set

1 of plates under this Section.

2 (Source: P.A. 95-157, eff. 1-1-08; 95-167, eff. 1-1-08; 95-353,
3 eff. 1-1-08; 95-876, eff. 8-21-08; 96-79, eff. 1-1-10.)

4 (625 ILCS 5/3-623) (from Ch. 95 1/2, par. 3-623)

5 Sec. 3-623. Purple Heart Plates. The Secretary, upon
6 receipt of an application made in the form prescribed by the
7 Secretary of State, may issue to recipients awarded the Purple
8 Heart by a branch of the armed forces of the United States who
9 reside in Illinois, special registration plates. The
10 Secretary, upon receipt of the proper application, may also
11 issue these special registration plates to an Illinois resident
12 who is the surviving spouse of a person who was awarded the
13 Purple Heart by a branch of the armed forces of the United
14 States. The special plates issued pursuant to this Section
15 should be affixed only to passenger vehicles of the 1st
16 division, including motorcycles, or motor vehicles of the 2nd
17 division weighing not more than 8,000 pounds. The Secretary
18 may, in his or her discretion, allow the plates to be issued as
19 vanity or personalized plates in accordance with Section
20 3-405.1 of this Code. The Secretary of State must make a
21 version of the special registration plates authorized under
22 this Section in a form appropriate for motorcycles.

23 The design and color of such plates shall be wholly within
24 the discretion of the Secretary of State. Appropriate
25 documentation, as determined by the Secretary, and the

1 appropriate registration fee shall accompany the application.
2 However, for an individual who has been issued Purple Heart
3 plates for a vehicle and who has been approved for benefits
4 under the Senior Citizens and Disabled Persons Property Tax
5 Relief ~~and Pharmaceutical Assistance~~ Act, the annual fee for
6 the registration of the vehicle shall be as provided in Section
7 3-806.3 of this Code.

8 (Source: P.A. 95-331, eff. 8-21-07; 95-353, eff. 1-1-08;
9 96-1101, eff. 1-1-11.)

10 (625 ILCS 5/3-626)

11 Sec. 3-626. Korean War Veteran license plates.

12 (a) In addition to any other special license plate, the
13 Secretary, upon receipt of all applicable fees and applications
14 made in the form prescribed by the Secretary of State, may
15 issue special registration plates designated as Korean War
16 Veteran license plates to residents of Illinois who
17 participated in the United States Armed Forces during the
18 Korean War. The special plate issued under this Section shall
19 be affixed only to passenger vehicles of the first division,
20 motorcycles, motor vehicles of the second division weighing not
21 more than 8,000 pounds, and recreational vehicles as defined by
22 Section 1-169 of this Code. Plates issued under this Section
23 shall expire according to the staggered multi-year procedure
24 established by Section 3-414.1 of this Code.

25 (b) The design, color, and format of the plates shall be

1 wholly within the discretion of the Secretary of State. The
2 Secretary may, in his or her discretion, allow the plates to be
3 issued as vanity plates or personalized in accordance with
4 Section 3-405.1 of this Code. The plates are not required to
5 designate "Land Of Lincoln", as prescribed in subsection (b) of
6 Section 3-412 of this Code. The Secretary shall prescribe the
7 eligibility requirements and, in his or her discretion, shall
8 approve and prescribe stickers or decals as provided under
9 Section 3-412.

10 (c) (Blank).

11 (d) The Korean War Memorial Construction Fund is created as
12 a special fund in the State treasury. All moneys in the Korean
13 War Memorial Construction Fund shall, subject to
14 appropriation, be used by the Department of Veteran Affairs to
15 provide grants for construction of the Korean War Memorial to
16 be located at Oak Ridge Cemetery in Springfield, Illinois. Upon
17 the completion of the Memorial, the Department of Veteran
18 Affairs shall certify to the State Treasurer that the
19 construction of the Memorial has been completed. Upon the
20 certification by the Department of Veteran Affairs, the State
21 Treasurer shall transfer all moneys in the Fund and any future
22 deposits into the Fund into the Secretary of State Special
23 License Plate Fund.

24 (e) An individual who has been issued Korean War Veteran
25 license plates for a vehicle and who has been approved for
26 benefits under the Senior Citizens and Disabled Persons

1 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay
2 the original issuance and the regular annual fee for the
3 registration of the vehicle as provided in Section 3-806.3 of
4 this Code in addition to the fees specified in subsection (c)
5 of this Section.

6 (Source: P.A. 96-1409, eff. 1-1-11.)

7 (625 ILCS 5/3-667)

8 Sec. 3-667. Korean Service license plates.

9 (a) In addition to any other special license plate, the
10 Secretary, upon receipt of all applicable fees and applications
11 made in the form prescribed by the Secretary of State, may
12 issue special registration plates designated as Korean Service
13 license plates to residents of Illinois who, on or after July
14 27, 1954, participated in the United States Armed Forces in
15 Korea. The special plate issued under this Section shall be
16 affixed only to passenger vehicles of the first division,
17 motorcycles, motor vehicles of the second division weighing not
18 more than 8,000 pounds, and recreational vehicles as defined by
19 Section 1-169 of this Code. Plates issued under this Section
20 shall expire according to the staggered multi-year procedure
21 established by Section 3-414.1 of this Code.

22 (b) The design, color, and format of the plates shall be
23 wholly within the discretion of the Secretary of State. The
24 Secretary may, in his or her discretion, allow the plates to be
25 issued as vanity or personalized plates in accordance with

1 Section 3-405.1 of this Code. The plates are not required to
2 designate "Land of Lincoln", as prescribed in subsection (b) of
3 Section 3-412 of this Code. The Secretary shall prescribe the
4 eligibility requirements and, in his or her discretion, shall
5 approve and prescribe stickers or decals as provided under
6 Section 3-412.

7 (c) An applicant shall be charged a \$2 fee for original
8 issuance in addition to the applicable registration fee. This
9 additional fee shall be deposited into the Korean War Memorial
10 Construction Fund a special fund in the State treasury.

11 (d) An individual who has been issued Korean Service
12 license plates for a vehicle and who has been approved for
13 benefits under the Senior Citizens and Disabled Persons
14 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay
15 the original issuance and the regular annual fee for the
16 registration of the vehicle as provided in Section 3-806.3 of
17 this Code in addition to the fees specified in subsection (c)
18 of this Section.

19 (Source: P.A. 97-306, eff. 1-1-12.)

20 (625 ILCS 5/3-683)

21 Sec. 3-683. Distinguished Service Cross license plates.
22 The Secretary, upon receipt of an application made in the form
23 prescribed by the Secretary of State, shall issue special
24 registration plates to any Illinois resident who has been
25 awarded the Distinguished Service Cross by a branch of the

1 armed forces of the United States. The Secretary, upon receipt
2 of the proper application, shall also issue these special
3 registration plates to an Illinois resident who is the
4 surviving spouse of a person who was awarded the Distinguished
5 Service Cross by a branch of the armed forces of the United
6 States. The special plates issued under this Section should be
7 affixed only to passenger vehicles of the first division,
8 including motorcycles, or motor vehicles of the second division
9 weighing not more than 8,000 pounds.

10 The design and color of the plates shall be wholly within
11 the discretion of the Secretary of State. Appropriate
12 documentation, as determined by the Secretary, and the
13 appropriate registration fee shall accompany the application.
14 However, for an individual who has been issued Distinguished
15 Service Cross plates for a vehicle and who has been approved
16 for benefits under the Senior Citizens and Disabled Persons
17 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, the
18 annual fee for the registration of the vehicle shall be as
19 provided in Section 3-806.3 of this Code.

20 (Source: P.A. 95-794, eff. 1-1-09; 96-328, eff. 8-11-09.)

21 (625 ILCS 5/3-806.3) (from Ch. 95 1/2, par. 3-806.3)

22 Sec. 3-806.3. Senior Citizens. Commencing with the 2009
23 registration year, the registration fee paid by any vehicle
24 owner who has been approved for benefits under the Senior
25 Citizens and Disabled Persons Property Tax Relief ~~and~~

1 ~~Pharmaceutical Assistance~~ Act or who is the spouse of such a
2 person shall be \$24 instead of the fee otherwise provided in
3 this Code for passenger cars displaying standard multi-year
4 registration plates issued under Section 3-414.1, motor
5 vehicles displaying special registration plates issued under
6 Section 3-609, 3-616, 3-621, 3-622, 3-623, 3-624, 3-625, 3-626,
7 3-628, 3-638, 3-642, 3-645, 3-647, 3-650, 3-651, or 3-663,
8 motor vehicles registered at 8,000 pounds or less under Section
9 3-815(a), and recreational vehicles registered at 8,000 pounds
10 or less under Section 3-815(b). Widows and widowers of
11 claimants shall also be entitled to this reduced registration
12 fee for the registration year in which the claimant was
13 eligible.

14 Commencing with the 2009 registration year, the
15 registration fee paid by any vehicle owner who has claimed and
16 received a grant under the Senior Citizens and Disabled Persons
17 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or who is
18 the spouse of such a person shall be \$24 instead of the fee
19 otherwise provided in this Code for passenger cars displaying
20 standard multi-year registration plates issued under Section
21 3-414.1, motor vehicles displaying special registration plates
22 issued under Section 3-607, 3-609, 3-616, 3-621, 3-622, 3-623,
23 3-624, 3-625, 3-626, 3-628, 3-638, 3-642, 3-645, 3-647, 3-650,
24 3-651, 3-663, or 3-664, motor vehicles registered at 8,000
25 pounds or less under Section 3-815(a), and recreational
26 vehicles registered at 8,000 pounds or less under Section

1 3-815(b). Widows and widowers of claimants shall also be
2 entitled to this reduced registration fee for the registration
3 year in which the claimant was eligible.

4 No more than one reduced registration fee under this
5 Section shall be allowed during any 12 month period based on
6 the primary eligibility of any individual, whether such reduced
7 registration fee is allowed to the individual or to the spouse,
8 widow or widower of such individual. This Section does not
9 apply to the fee paid in addition to the registration fee for
10 motor vehicles displaying vanity or special license plates.

11 (Source: P.A. 95-157, eff. 1-1-08; 95-331, eff. 8-21-07;
12 95-876, eff. 8-21-08; 96-554, eff. 1-1-10.)

13 (625 ILCS 5/11-1301.2) (from Ch. 95 1/2, par. 11-1301.2)

14 Sec. 11-1301.2. Special decals for parking; persons with
15 disabilities.

16 (a) The Secretary of State shall provide for, by
17 administrative rules, the design, size, color, and placement of
18 a person with disabilities motorist decal or device and shall
19 provide for, by administrative rules, the content and form of
20 an application for a person with disabilities motorist decal or
21 device, which shall be used by local authorities in the
22 issuance thereof to a person with temporary disabilities,
23 provided that the decal or device is valid for no more than 90
24 days, subject to renewal for like periods based upon continued
25 disability, and further provided that the decal or device

1 clearly sets forth the date that the decal or device expires.
2 The application shall include the requirement of an Illinois
3 Identification Card number or a State of Illinois driver's
4 license number. This decal or device may be used by the
5 authorized holder to designate and identify a vehicle not owned
6 or displaying a registration plate as provided in Sections
7 3-609 and 3-616 of this Act to designate when the vehicle is
8 being used to transport said person or persons with
9 disabilities, and thus is entitled to enjoy all the privileges
10 that would be afforded a person with disabilities licensed
11 vehicle. Person with disabilities decals or devices issued and
12 displayed pursuant to this Section shall be recognized and
13 honored by all local authorities regardless of which local
14 authority issued such decal or device.

15 The decal or device shall be issued only upon a showing by
16 adequate documentation that the person for whose benefit the
17 decal or device is to be used has a temporary disability as
18 defined in Section 1-159.1 of this Code.

19 (b) The local governing authorities shall be responsible
20 for the provision of such decal or device, its issuance and
21 designated placement within the vehicle. The cost of such decal
22 or device shall be at the discretion of such local governing
23 authority.

24 (c) The Secretary of State may, pursuant to Section
25 3-616(c), issue a person with disabilities parking decal or
26 device to a person with disabilities as defined by Section

1 1-159.1. Any person with disabilities parking decal or device
2 issued by the Secretary of State shall be registered to that
3 person with disabilities in the form to be prescribed by the
4 Secretary of State. The person with disabilities parking decal
5 or device shall not display that person's address. One
6 additional decal or device may be issued to an applicant upon
7 his or her written request and with the approval of the
8 Secretary of State. The written request must include a
9 justification of the need for the additional decal or device.

10 (d) Replacement decals or devices may be issued for lost,
11 stolen, or destroyed decals upon application and payment of a
12 \$10 fee. The replacement fee may be waived for individuals that
13 have claimed and received a grant under the Senior Citizens and
14 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
15 ~~Assistance~~ Act.

16 (Source: P.A. 95-167, eff. 1-1-08; 96-72, eff. 1-1-10; 96-79,
17 eff. 1-1-10; 96-1000, eff. 7-2-10.)

18 Section 975. The Criminal Code of 1961 is amended by
19 changing Section 17-6.5 as follows:

20 (720 ILCS 5/17-6.5)

21 Sec. 17-6.5. Persons under deportation order;
22 ineligibility for benefits.

23 (a) An individual against whom a United States Immigration
24 Judge has issued an order of deportation which has been

1 affirmed by the Board of Immigration Review, as well as an
2 individual who appeals such an order pending appeal, under
3 paragraph 19 of Section 241(a) of the Immigration and
4 Nationality Act relating to persecution of others on account of
5 race, religion, national origin or political opinion under the
6 direction of or in association with the Nazi government of
7 Germany or its allies, shall be ineligible for the following
8 benefits authorized by State law:

9 (1) The homestead exemptions and homestead improvement
10 exemption under Sections 15-170, 15-175, 15-176, and
11 15-180 of the Property Tax Code.

12 (2) Grants under the Senior Citizens and Disabled
13 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~
14 Act.

15 (3) The double income tax exemption conferred upon
16 persons 65 years of age or older by Section 204 of the
17 Illinois Income Tax Act.

18 (4) Grants provided by the Department on Aging.

19 (5) Reductions in vehicle registration fees under
20 Section 3-806.3 of the Illinois Vehicle Code.

21 (6) Free fishing and reduced fishing license fees under
22 Sections 20-5 and 20-40 of the Fish and Aquatic Life Code.

23 (7) Tuition free courses for senior citizens under the
24 Senior Citizen Courses Act.

25 (8) Any benefits under the Illinois Public Aid Code.

26 (b) If a person has been found by a court to have knowingly

1 received benefits in violation of subsection (a) and:

2 (1) the total monetary value of the benefits received
3 is less than \$150, the person is guilty of a Class A
4 misdemeanor; a second or subsequent violation is a Class 4
5 felony;

6 (2) the total monetary value of the benefits received
7 is \$150 or more but less than \$1,000, the person is guilty
8 of a Class 4 felony; a second or subsequent violation is a
9 Class 3 felony;

10 (3) the total monetary value of the benefits received
11 is \$1,000 or more but less than \$5,000, the person is
12 guilty of a Class 3 felony; a second or subsequent
13 violation is a Class 2 felony;

14 (4) the total monetary value of the benefits received
15 is \$5,000 or more but less than \$10,000, the person is
16 guilty of a Class 2 felony; a second or subsequent
17 violation is a Class 1 felony; or

18 (5) the total monetary value of the benefits received
19 is \$10,000 or more, the person is guilty of a Class 1
20 felony.

21 (c) For purposes of determining the classification of an
22 offense under this Section, all of the monetary value of the
23 benefits received as a result of the unlawful act, practice, or
24 course of conduct may be accumulated.

25 (d) Any grants awarded to persons described in subsection
26 (a) may be recovered by the State of Illinois in a civil action

1 commenced by the Attorney General in the circuit court of
2 Sangamon County or the State's Attorney of the county of
3 residence of the person described in subsection (a).

4 (e) An individual described in subsection (a) who has been
5 deported shall be restored to any benefits which that
6 individual has been denied under State law pursuant to
7 subsection (a) if (i) the Attorney General of the United States
8 has issued an order cancelling deportation and has adjusted the
9 status of the individual to that of an alien lawfully admitted
10 for permanent residence in the United States or (ii) the
11 country to which the individual has been deported adjudicates
12 or exonerates the individual in a judicial or administrative
13 proceeding as not being guilty of the persecution of others on
14 account of race, religion, national origin, or political
15 opinion under the direction of or in association with the Nazi
16 government of Germany or its allies.

17 (Source: P.A. 96-1551, eff. 7-1-11.)

18 Section 995. Severability. If any provision of this Act or
19 application thereof to any person or circumstance is held
20 invalid, such invalidity does not affect other provisions or
21 applications of this Act which can be given effect without the
22 invalid application or provision, and to this end the
23 provisions of this Act are declared to be severable.

24 Section 999. Effective date. This Act takes effect upon

1 becoming law, except that Sections 15, 20, 30, and 85 take
2 effect on July 1, 2012.".