



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2221

by Rep. Chris Miller

SYNOPSIS AS INTRODUCED:

See Index

Creates the No Taxpayer Funding for Abortion Act. Provides that neither the State nor any of its subdivisions may authorize the use of, appropriate, or expend funds to pay for an abortion or to cover any part of the costs of a health plan that includes coverage of abortion or to provide or refer for an abortion, unless a woman who suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death if an abortion is not performed. Amends the State Employees Group Insurance Act of 1971 and the Illinois Public Aid Code. Excludes from the programs of health benefits and services authorized under those Acts coverage for elective abortions as provided in the No Taxpayer Funding for Abortion Act. Prohibits a physician who has been found guilty of performing an abortion procedure in a willful and wanton manner upon a woman who was not pregnant when the abortion procedure was performed from participating in the State's Medical Assistance Program. Provides that the Department of Healthcare and Family Services shall require a written statement, including the required opinion of a physician, to accompany a claim for reimbursement for abortions or induced miscarriages or premature births. Makes other changes. Amends the Problem Pregnancy Health Services and Care Act. Permits the Department of Human Services to make grants to nonprofit agencies and organizations that do not use those grants to refer or counsel for, or perform, abortions. Contains provisions regarding applicability and preempts home rule. Effective June 1, 2019.

LRB101 10265 KTG 55370 b

FISCAL NOTE ACT
MAY APPLY

HOME RULE NOTE
ACT MAY APPLY

A BILL FOR

1 AN ACT concerning abortion.

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

4 Section 1. Short title. This Act may be cited as the No
5 Taxpayer Funding for Abortion Act.

6 Section 5. Public policy. It is the public policy of this
7 State that the General Assembly of the State of Illinois does
8 solemnly declare and find in reaffirmation of the longstanding
9 policy of this State that the unborn child is a human being
10 from the time of conception and has a right to life and, to the
11 extent consistent with the United States Constitution,
12 Illinois law should be interpreted to recognize that right to
13 life and to protect unborn life.

14 The General Assembly further declares and finds that, while
15 the people of Illinois hold a variety of positions on the issue
16 of abortion, they generally oppose the use of tax dollars to
17 pay for elective abortions and support the federal Hyde
18 Amendment, named after the late Henry J. Hyde, whose memory is
19 revered and service celebrated as a Congressman from the great
20 State of Illinois. This Act honors the strong beliefs of the
21 people of Illinois by prohibiting the taxpayer funding of
22 abortion in this State.

1 Section 10. Use of funds to pay for abortions prohibited;
2 exceptions. Notwithstanding any other provision of law,
3 neither the State nor any of its subdivisions may authorize the
4 use of, appropriate, or expend any funds to pay for any
5 abortion or to cover any part of the costs of any health plan
6 that includes coverage of abortion or to provide or refer for
7 any abortion, except in the case where a woman suffers from a
8 physical disorder, physical injury, or physical illness that
9 would, as certified by a physician, place the woman in danger
10 of death unless an abortion is performed, including a
11 life-endangering physical condition caused by or arising from
12 the pregnancy itself, or in such other circumstances as
13 required by federal law.

14 Section 900. The State Employees Group Insurance Act of
15 1971 is amended by changing Sections 6 and 6.1 as follows:

16 (5 ILCS 375/6) (from Ch. 127, par. 526)

17 Sec. 6. Program of health benefits.

18 (a) The program of health benefits shall provide for
19 protection against the financial costs of health care expenses
20 incurred in and out of hospital including basic
21 hospital-surgical-medical coverages. The program may include,
22 but shall not be limited to, such supplemental coverages as
23 out-patient diagnostic X-ray and laboratory expenses,
24 prescription drugs, dental services, hearing evaluations,

1 hearing aids, the dispensing and fitting of hearing aids, and
2 similar group benefits as are now or may become available,
3 except as provided in the No Taxpayer Funding for Abortion Act.
4 The program may also include coverage for those who rely on
5 treatment by prayer or spiritual means alone for healing in
6 accordance with the tenets and practice of a recognized
7 religious denomination.

8 The program of health benefits shall be designed by the
9 Director (1) to provide a reasonable relationship between the
10 benefits to be included and the expected distribution of
11 expenses of each such type to be incurred by the covered
12 members and dependents, (2) to specify, as covered benefits and
13 as optional benefits, the medical services of practitioners in
14 all categories licensed under the Medical Practice Act of 1987,
15 (3) to include reasonable controls, which may include
16 deductible and co-insurance provisions, applicable to some or
17 all of the benefits, or a coordination of benefits provision,
18 to prevent or minimize unnecessary utilization of the various
19 hospital, surgical and medical expenses to be provided and to
20 provide reasonable assurance of stability of the program, and
21 (4) to provide benefits to the extent possible to members
22 throughout the State, wherever located, on an equitable basis.
23 Notwithstanding any other provision of this Section or Act, for
24 all members or dependents who are eligible for benefits under
25 Social Security or the Railroad Retirement system or who had
26 sufficient Medicare-covered government employment, the

1 Department shall reduce benefits which would otherwise be paid
2 by Medicare, by the amount of benefits for which the member or
3 dependents are eligible under Medicare, except that such
4 reduction in benefits shall apply only to those members or
5 dependents who (1) first become eligible for such medicare
6 coverage on or after the effective date of this amendatory Act
7 of 1992; or (2) are Medicare-eligible members or dependents of
8 a local government unit which began participation in the
9 program on or after July 1, 1992; or (3) remain eligible for
10 but no longer receive Medicare coverage which they had been
11 receiving on or after the effective date of this amendatory Act
12 of 1992.

13 Notwithstanding any other provisions of this Act, where a
14 covered member or dependents are eligible for benefits under
15 the federal Medicare health insurance program (Title XVIII of
16 the Social Security Act as added by Public Law 89-97, 89th
17 Congress), benefits paid under the State of Illinois program or
18 plan will be reduced by the amount of benefits paid by
19 Medicare. For members or dependents who are eligible for
20 benefits under Social Security or the Railroad Retirement
21 system or who had sufficient Medicare-covered government
22 employment, benefits shall be reduced by the amount for which
23 the member or dependent is eligible under Medicare, except that
24 such reduction in benefits shall apply only to those members or
25 dependents who (1) first become eligible for such Medicare
26 coverage on or after the effective date of this amendatory Act

1 of 1992; or (2) are Medicare-eligible members or dependents of
2 a local government unit which began participation in the
3 program on or after July 1, 1992; or (3) remain eligible for,
4 but no longer receive Medicare coverage which they had been
5 receiving on or after the effective date of this amendatory Act
6 of 1992. Premiums may be adjusted, where applicable, to an
7 amount deemed by the Director to be reasonably consistent with
8 any reduction of benefits.

9 (b) A member, not otherwise covered by this Act, who has
10 retired as a participating member under Article 2 of the
11 Illinois Pension Code but is ineligible for the retirement
12 annuity under Section 2-119 of the Illinois Pension Code, shall
13 pay the premiums for coverage, not exceeding the amount paid by
14 the State for the non-contributory coverage for other members,
15 under the group health benefits program under this Act. The
16 Director shall determine the premiums to be paid by a member
17 under this subsection (b).

18 (Source: P.A. 100-538, eff. 1-1-18.)

19 (5 ILCS 375/6.1) (from Ch. 127, par. 526.1)

20 Sec. 6.1. The program of health benefits may offer as an
21 alternative, available on an optional basis, coverage through
22 health maintenance organizations. That part of the premium for
23 such coverage which is in excess of the amount which would
24 otherwise be paid by the State for the program of health
25 benefits shall be paid by the member who elects such

1 alternative coverage and shall be collected as provided for
2 premiums for other optional coverages, except as provided in
3 the No Taxpayer Funding for Abortion Act.

4 (Source: P.A. 100-538, eff. 1-1-18.)

5 Section 905. The Illinois Public Aid Code is amended by
6 changing Sections 5-5, 5-8, 5-9, and 6-1 as follows:

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

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

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

1 laws of this State, except as provided in the No Taxpayer
2 Funding for Abortion Act. The Illinois Department, by rule,
3 shall prohibit any physician from providing medical assistance
4 to anyone eligible therefor under this Code where such
5 physician has been found guilty of performing an abortion
6 procedure in a willful and wanton manner upon a woman who was
7 not pregnant at the time such abortion procedure was performed.

8 The term "any other type of remedial care" shall include
9 nursing care and nursing home service for persons who rely on
10 treatment by spiritual means alone through prayer for healing.

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

18 Notwithstanding any other provision of this Code,
19 reproductive health care that is otherwise legal in Illinois
20 shall be covered under the medical assistance program for
21 persons who are otherwise eligible for medical assistance under
22 this Article, except as provided in the No Taxpayer Funding for
23 Abortion Act.

24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

23 On and after July 1, 2012, the Department of Healthcare and
24 Family Services may provide the following services to persons
25 eligible for assistance under this Article who are
26 participating in education, training or employment programs

1 operated by the Department of Human Services as successor to
2 the Department of Public Aid:

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

5 (2) eyeglasses prescribed by a physician skilled in the
6 diseases of the eye, or by an optometrist, whichever the
7 person may select.

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

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

1 to persons under the age of 18 under the medical assistance
2 program.

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

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

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

26 The Illinois Department shall authorize the provision of,

1 and shall authorize payment for, screening by low-dose
2 mammography for the presence of occult breast cancer for women
3 35 years of age or older who are eligible for medical
4 assistance under this Article, as follows:

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

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

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

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

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

22 All screenings shall include a physical breast exam,
23 instruction on self-examination and information regarding the
24 frequency of self-examination and its value as a preventative
25 tool. For purposes of this Section, "low-dose mammography"
26 means the x-ray examination of the breast using equipment

1 dedicated specifically for mammography, including the x-ray
2 tube, filter, compression device, and image receptor, with an
3 average radiation exposure delivery of less than one rad per
4 breast for 2 views of an average size breast. The term also
5 includes digital mammography and includes breast
6 tomosynthesis. As used in this Section, the term "breast
7 tomosynthesis" means a radiologic procedure that involves the
8 acquisition of projection images over the stationary breast to
9 produce cross-sectional digital three-dimensional images of
10 the breast. If, at any time, the Secretary of the United States
11 Department of Health and Human Services, or its successor
12 agency, promulgates rules or regulations to be published in the
13 Federal Register or publishes a comment in the Federal Register
14 or issues an opinion, guidance, or other action that would
15 require the State, pursuant to any provision of the Patient
16 Protection and Affordable Care Act (Public Law 111-148),
17 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
18 successor provision, to defray the cost of any coverage for
19 breast tomosynthesis outlined in this paragraph, then the
20 requirement that an insurer cover breast tomosynthesis is
21 inoperative other than any such coverage authorized under
22 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
23 the State shall not assume any obligation for the cost of
24 coverage for breast tomosynthesis set forth in this paragraph.

25 On and after January 1, 2016, the Department shall ensure
26 that all networks of care for adult clients of the Department

1 include access to at least one breast imaging Center of Imaging
2 Excellence as certified by the American College of Radiology.

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

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

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

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

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

1 These clinics or centers may also collaborate with other
2 hospital-based mammography facilities. By January 1, 2016, the
3 Department shall report to the General Assembly on the status
4 of the provision set forth in this paragraph.

5 The Department shall establish a methodology to remind
6 women who are age-appropriate for screening mammography, but
7 who have not received a mammogram within the previous 18
8 months, of the importance and benefit of screening mammography.
9 The Department shall work with experts in breast cancer
10 outreach and patient navigation to optimize these reminders and
11 shall establish a methodology for evaluating their
12 effectiveness and modifying the methodology based on the
13 evaluation.

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

20 The Department shall devise a means of case-managing or
21 patient navigation for beneficiaries diagnosed with breast
22 cancer. This program shall initially operate as a pilot program
23 in areas of the State with the highest incidence of mortality
24 related to breast cancer. At least one pilot program site shall
25 be in the metropolitan Chicago area and at least one site shall
26 be outside the metropolitan Chicago area. On or after July 1,

1 2016, the pilot program shall be expanded to include one site
2 in western Illinois, one site in southern Illinois, one site in
3 central Illinois, and 4 sites within metropolitan Chicago. An
4 evaluation of the pilot program shall be carried out measuring
5 health outcomes and cost of care for those served by the pilot
6 program compared to similarly situated patients who are not
7 served by the pilot program.

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

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

1 All medical providers providing medical assistance to
2 pregnant women under this Code shall receive information from
3 the Department on the availability of services under any
4 program providing case management services for addicted women,
5 including information on appropriate referrals for other
6 social services that may be needed by addicted women in
7 addition to treatment for addiction.

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

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

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

1 procedures to the Illinois Department.

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

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

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

26 (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

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

1 proof of receipt, unless the Illinois Department shall have put
2 into effect and shall be operating a system of post-payment
3 audit and review which shall, on a sampling basis, be deemed
4 adequate by the Illinois Department to assure that such drugs,
5 dentures, prosthetic devices and eyeglasses for which payment
6 is being made are actually being received by eligible
7 recipients. Within 90 days after September 16, 1984 (the
8 effective date of Public Act 83-1439), the Illinois Department
9 shall establish a current list of acquisition costs for all
10 prosthetic devices and any other items recognized as medical
11 equipment and supplies reimbursable under this Article and
12 shall update such list on a quarterly basis, except that the
13 acquisition costs of all prescription drugs shall be updated no
14 less frequently than every 30 days as required by Section
15 5-5.12.

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

22 Notwithstanding any other law to the contrary, the Illinois
23 Department shall, within 365 days after July 22, 2013 (the
24 effective date of Public Act 98-104), establish procedures to
25 permit skilled care facilities licensed under the Nursing Home
26 Care Act to submit monthly billing claims for reimbursement

1 purposes. Following development of these procedures, the
2 Department shall, by July 1, 2016, test the viability of the
3 new system and implement any necessary operational or
4 structural changes to its information technology platforms in
5 order to allow for the direct acceptance and payment of nursing
6 home claims.

7 Notwithstanding any other law to the contrary, the Illinois
8 Department shall, within 365 days after August 15, 2014 (the
9 effective date of Public Act 98-963), establish procedures to
10 permit ID/DD facilities licensed under the ID/DD Community Care
11 Act and MC/DD facilities licensed under the MC/DD Act to submit
12 monthly billing claims for reimbursement purposes. Following
13 development of these procedures, the Department shall have an
14 additional 365 days to test the viability of the new system and
15 to ensure that any necessary operational or structural changes
16 to its information technology platforms are implemented.

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

26 The Illinois Department may require that all dispensers of

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

8 Enrollment of a vendor shall be subject to a provisional
9 period and shall be conditional for one year. During the period
10 of conditional enrollment, the Department may terminate the
11 vendor's eligibility to participate in, or may disenroll the
12 vendor from, the medical assistance program without cause.
13 Unless otherwise specified, such termination of eligibility or
14 disenrollment is not subject to the Department's hearing
15 process. However, a disenrolled vendor may reapply without
16 penalty.

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

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

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

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

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

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

1 complete.

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

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

9 (4) In the case of a provider operated by a unit of
10 local government with a population exceeding 3,000,000
11 when local government funds finance federal participation
12 for claims payments.

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

20 In the case of long term care facilities, within 45
21 calendar days of receipt by the facility of required
22 prescreening information, new admissions with associated
23 admission documents shall be submitted through the Medical
24 Electronic Data Interchange (MEDI) or the Recipient
25 Eligibility Verification (REV) System or shall be submitted
26 directly to the Department of Human Services using required

1 admission forms. Effective September 1, 2014, admission
2 documents, including all prescreening information, must be
3 submitted through MEDI or REV. Confirmation numbers assigned to
4 an accepted transaction shall be retained by a facility to
5 verify timely submittal. Once an admission transaction has been
6 completed, all resubmitted claims following prior rejection
7 are subject to receipt no later than 180 days after the
8 admission transaction has been completed.

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

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

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

17 Beginning in fiscal year 2013, the Illinois Department
18 shall set forth a request for information to identify the
19 benefits of a pre-payment, post-adjudication, and post-edit
20 claims system with the goals of streamlining claims processing
21 and provider reimbursement, reducing the number of pending or
22 rejected claims, and helping to ensure a more transparent
23 adjudication process through the utilization of: (i) provider
24 data verification and provider screening technology; and (ii)
25 clinical code editing; and (iii) pre-pay, pre- or
26 post-adjudicated predictive modeling with an integrated case

1 management system with link analysis. Such a request for
2 information shall not be considered as a request for proposal
3 or as an obligation on the part of the Illinois Department to
4 take any action or acquire any products or services.

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

26 The Department shall require, by rule, all providers of

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

8 In order to promote environmental responsibility, meet the
9 needs of recipients and enrollees, and achieve significant cost
10 savings, the Department, or a managed care organization under
11 contract with the Department, may provide recipients or managed
12 care enrollees who have a prescription or Certificate of
13 Medical Necessity access to refurbished durable medical
14 equipment under this Section (excluding prosthetic and
15 orthotic devices as defined in the Orthotics, Prosthetics, and
16 Pedorthics Practice Act and complex rehabilitation technology
17 products and associated services) through the State's
18 assistive technology program's reutilization program, using
19 staff with the Assistive Technology Professional (ATP)
20 Certification if the refurbished durable medical equipment:
21 (i) is available; (ii) is less expensive, including shipping
22 costs, than new durable medical equipment of the same type;
23 (iii) is able to withstand at least 3 years of use; (iv) is
24 cleaned, disinfected, sterilized, and safe in accordance with
25 federal Food and Drug Administration regulations and guidance
26 governing the reprocessing of medical devices in health care

1 settings; and (v) equally meets the needs of the recipient or
2 enrollee. The reutilization program shall confirm that the
3 recipient or enrollee is not already in receipt of same or
4 similar equipment from another service provider, and that the
5 refurbished durable medical equipment equally meets the needs
6 of the recipient or enrollee. Nothing in this paragraph shall
7 be construed to limit recipient or enrollee choice to obtain
8 new durable medical equipment or place any additional prior
9 authorization conditions on enrollees of managed care
10 organizations.

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

1 (iv) no later than July 1, 2013, minimum level of care
2 eligibility criteria for institutional and home and
3 community-based long term care; and (v) no later than October
4 1, 2013, establish procedures to permit long term care
5 providers access to eligibility scores for individuals with an
6 admission date who are seeking or receiving services from the
7 long term care provider. In order to select the minimum level
8 of care eligibility criteria, the Governor shall establish a
9 workgroup that includes affected agency representatives and
10 stakeholders representing the institutional and home and
11 community-based long term care interests. This Section shall
12 not restrict the Department from implementing lower level of
13 care eligibility criteria for community-based services in
14 circumstances where federal approval has been granted.

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

22 The Illinois Department shall report annually to the
23 General Assembly, no later than the second Friday in April of
24 1979 and each year thereafter, in regard to:

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

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

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

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

7 The period covered by each report shall be the 3 years
8 ending on the June 30 prior to the report. The report shall
9 include suggested legislation for consideration by the General
10 Assembly. The requirement for reporting to the General Assembly
11 shall be satisfied by filing copies of the report as required
12 by Section 3.1 of the General Assembly Organization Act, and
13 filing such additional copies with the State Government Report
14 Distribution Center for the General Assembly as is required
15 under paragraph (t) of Section 7 of the State Library Act.

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

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 Because kidney transplantation can be an appropriate,
2 cost-effective alternative to renal dialysis when medically
3 necessary and notwithstanding the provisions of Section 1-11 of
4 this Code, beginning October 1, 2014, the Department shall
5 cover kidney transplantation for noncitizens with end-stage
6 renal disease who are not eligible for comprehensive medical
7 benefits, who meet the residency requirements of Section 5-3 of
8 this Code, and who would otherwise meet the financial
9 requirements of the appropriate class of eligible persons under
10 Section 5-2 of this Code. To qualify for coverage of kidney
11 transplantation, such person must be receiving emergency renal
12 dialysis services covered by the Department. Providers under
13 this Section shall be prior approved and certified by the
14 Department to perform kidney transplantation and the services
15 under this Section shall be limited to services associated with
16 kidney transplantation.

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

1 lifetime restriction limit mandate.

2 On or after July 1, 2015, opioid antagonists prescribed for
3 the treatment of an opioid overdose, including the medication
4 product, administration devices, and any pharmacy fees related
5 to the dispensing and administration of the opioid antagonist,
6 shall be covered under the medical assistance program for
7 persons who are otherwise eligible for medical assistance under
8 this Article. As used in this Section, "opioid antagonist"
9 means a drug that binds to opioid receptors and blocks or
10 inhibits the effect of opioids acting on those receptors,
11 including, but not limited to, naloxone hydrochloride or any
12 other similarly acting drug approved by the U.S. Food and Drug
13 Administration.

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

26 A federally qualified health center, as defined in Section

1 1905(1)(2)(B) of the federal Social Security Act, shall be
2 reimbursed by the Department in accordance with the federally
3 qualified health center's encounter rate for services provided
4 to medical assistance recipients that are performed by a dental
5 hygienist, as defined under the Illinois Dental Practice Act,
6 working under the general supervision of a dentist and employed
7 by a federally qualified health center.

8 Notwithstanding any other provision of this Code, the
9 Illinois Department shall authorize licensed dietitian
10 nutritionists and certified diabetes educators to counsel
11 senior diabetes patients in the senior diabetes patients' homes
12 to remove the hurdle of transportation for senior diabetes
13 patients to receive treatment.

14 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
15 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
16 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
17 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
18 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
19 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
20 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.
21 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;
22 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.
23 12-10-18.)

24 (305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

25 Sec. 5-8. Practitioners. In supplying medical assistance,

1 the Illinois Department may provide for the legally authorized
2 services of (i) persons licensed under the Medical Practice Act
3 of 1987, as amended, except as hereafter in this Section
4 stated, whether under a general or limited license, (ii)
5 persons licensed under the Nurse Practice Act as advanced
6 practice registered nurses, regardless of whether or not the
7 persons have written collaborative agreements, (iii) persons
8 licensed or registered under other laws of this State to
9 provide dental, medical, pharmaceutical, optometric,
10 podiatric, or nursing services, or other remedial care
11 recognized under State law, (iv) persons licensed under other
12 laws of this State as a clinical social worker, and (v) persons
13 licensed under other laws of this State as physician
14 assistants. The Department shall adopt rules, no later than 90
15 days after January 1, 2017 (the effective date of Public Act
16 99-621), for the legally authorized services of persons
17 licensed under other laws of this State as a clinical social
18 worker. The Department may not provide for legally authorized
19 services of any physician who has been convicted of having
20 performed an abortion procedure in a willful and wanton manner
21 on a woman who was not pregnant at the time such abortion
22 procedure was performed. The utilization of the services of
23 persons engaged in the treatment or care of the sick, which
24 persons are not required to be licensed or registered under the
25 laws of this State, is not prohibited by this Section.

26 (Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17;

1 100-453, eff. 8-25-17; 100-513, eff. 1-1-18; 100-538, eff.
2 1-1-18; 100-863, eff. 8-14-18.)

3 (305 ILCS 5/5-9) (from Ch. 23, par. 5-9)

4 Sec. 5-9. Choice of medical dispensers. Applicants and
5 recipients shall be entitled to free choice of those qualified
6 practitioners, hospitals, nursing homes, and other dispensers
7 of medical services meeting the requirements and complying with
8 the rules and regulations of the Illinois Department. However,
9 the Director of Healthcare and Family Services may, after
10 providing reasonable notice and opportunity for hearing, deny,
11 suspend or terminate any otherwise qualified person, firm,
12 corporation, association, agency, institution, or other legal
13 entity, from participation as a vendor of goods or services
14 under the medical assistance program authorized by this Article
15 if the Director finds such vendor of medical services in
16 violation of this Act or the policy or rules and regulations
17 issued pursuant to this Act. Any physician who has been
18 convicted of performing an abortion procedure in a willful and
19 wanton manner upon a woman who was not pregnant at the time
20 such abortion procedure was performed shall be automatically
21 removed from the list of physicians qualified to participate as
22 a vendor of medical services under the medical assistance
23 program authorized by this Article.

24 (Source: P.A. 100-538, eff. 1-1-18.)

1 (305 ILCS 5/6-1) (from Ch. 23, par. 6-1)

2 Sec. 6-1. Eligibility requirements. Financial aid in
3 meeting basic maintenance requirements shall be given under
4 this Article to or in behalf of persons who meet the
5 eligibility conditions of Sections 6-1.1 through 6-1.10,
6 except as provided in the No Taxpayer Funding for Abortion Act.

7 In addition, each unit of local government subject to this
8 Article shall provide persons receiving financial aid in
9 meeting basic maintenance requirements with financial aid for
10 either (a) necessary treatment, care, and supplies required
11 because of illness or disability, or (b) acute medical
12 treatment, care, and supplies only. If a local governmental
13 unit elects to provide financial aid for acute medical
14 treatment, care, and supplies only, the general types of acute
15 medical treatment, care, and supplies for which financial aid
16 is provided shall be specified in the general assistance rules
17 of the local governmental unit, which rules shall provide that
18 financial aid is provided, at a minimum, for acute medical
19 treatment, care, or supplies necessitated by a medical
20 condition for which prior approval or authorization of medical
21 treatment, care, or supplies is not required by the general
22 assistance rules of the Illinois Department.

23 (Source: P.A. 100-538, eff. 1-1-18.)

24 Section 910. The Problem Pregnancy Health Services and Care
25 Act is amended by changing Section 4-100 as follows:

1 (410 ILCS 230/4-100) (from Ch. 111 1/2, par. 4604-100)

2 Sec. 4-100. The Department may make grants to nonprofit
3 agencies and organizations which do not use such grants to
4 refer or counsel for, or perform, abortions and which
5 coordinate and establish linkages among services that will
6 further the purposes of this Act and, where appropriate, will
7 provide, supplement, or improve the quality of such services.

8 (Source: P.A. 100-538, eff. 1-1-18.)

9 Section 990. Application of Act; home rule powers.

10 (a) This Act applies to all State and local (including home
11 rule unit) laws, ordinances, policies, procedures, practices,
12 and governmental actions and their implementation, whether
13 statutory or otherwise and whether adopted before or after the
14 effective date of this Act.

15 (b) A home rule unit may not adopt any rule in a manner
16 inconsistent with this Act. This Act is a limitation under
17 subsection (i) of Section 6 of Article VII of the Illinois
18 Constitution on the concurrent exercise by home rule units of
19 powers and functions exercised by the State.

20 Section 999. Effective date. This Act takes effect June 1,
21 2019.

1 INDEX

2 Statutes amended in order of appearance

3 New Act

4 5 ILCS 375/6 from Ch. 127, par. 526

5 5 ILCS 375/6.1 from Ch. 127, par. 526.1

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

7 305 ILCS 5/5-8 from Ch. 23, par. 5-8

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

9 305 ILCS 5/6-1 from Ch. 23, par. 6-1

10 410 ILCS 230/4-100 from Ch. 111 1/2, par. 4604-100