SB2017

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101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB2017

Introduced 2/15/2019, by Sen. Martin A. Sandoval

SYNOPSIS AS INTRODUCED:

See Index

Amends the Covering ALL KIDS Health Insurance Act. Changes the short title of the Act to the Covering ALL KIDS and Young Adults Health Insurance Act and makes conforming changes in various Acts. Changes the name of the Covering ALL KIDS Health Insurance Program to the Covering ALL KIDS Young Adults Health Insurance Program and makes conforming changes. Provides that the Department of Healthcare and Family services shall purchase or provide healthcare benefits for eligible young adults that are identical to the benefits provided for individuals under the Medical Assistance Program established under the Illinois Public Aid Code. Defines young adult.

LRB101 09603 RAB 54701 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Mental Health and Developmental
5 Disabilities Administrative Act is amended by changing Section
6 71a as follows:

7 (20 ILCS 1705/71a)
8 Sec. 71a. Community Behavioral Health Care.
9 (a) The Department shall strive to guarantee that persons,
10 including children, suffering from mental illness, substance
11 abuse, and other behavioral disorders have access to locally
12 accessible behavioral health care providers who have the
13 ability to treat the person's conditions in a cost effective,
14 outcome-based manner. To ensure continuity and quality of care
15 that is integrated with the person's overall medical care, the
16 Department shall:
17 (1) Designate as essential community behavioral health
18 care providers organizations that meet the qualifications
19 set forth in subsection (b) of this Section.
20 (2) Promote the co-location of primary and behavioral
21 health care services centers.
22 (3) Promote access to necessary behavioral health care
23 services in the State's Health Insurance Exchange

1 policies.

2 (4) Promote continuity of care for persons moving
3 between Medicaid, SCHIP, and programs administered by the
4 Department that provide behavioral health care services.

5 (5) Promote continuity of care for persons not yet
6 eligible for Medicaid or who are without insurance coverage
7 for their conditions.

8 (6) Work toward improving access in Illinois'
9 underserved and health professional shortage areas.

10 (b) The Department shall designate certain community
11 behavioral health care providers as essential community
12 behavioral health care providers. To qualify for the
13 designation an organization must be a not-for-profit
14 organization under the Internal Revenue Code or a governmental
15 entity that:

16 (1) Demonstrates a commitment to serving low-income
17 and underserved populations.

18 (2) Provides outcome-based community behavioral health
19 care treatment or services.

20 (3) Does not restrict access or services because of a
21 client's financial limitation.

22 (4) Is a community behavioral health care provider
23 certified by the Department, or a licensed community
24 behavioral health care provider holding a purchase of care
25 contract with the State under the State's Medicaid program.
26 An organization that is licensed or certified by the

1 Department may apply to the Department for designation as an
2 essential community behavioral health care provider. The
3 Department, through administrative rule, shall describe the
4 standards and process of designating an essential community
5 behavioral health care provider, establishing the community to
6 be served, other criteria for selection, and grounds for
7 termination.

8 (c) An organization designated as an essential community
9 behavioral health care provider under subsection (b) and all
10 members of the care treatment and service staff of the
11 essential community behavioral health care provider shall
12 agree to serve enrollees of all health insurers or health care
13 service contractors operating in the area that the designated
14 essential community behavioral health care provider serves.
15 Health insurers shall include State programs funded under Title
16 XIX and Title XXI of the federal Social Security Act, including
17 the State's Medicaid program and the Covering ALL KIDS and
18 Young Adults Health Insurance Program; other programs funded by
19 the Department of Healthcare and Family Services for non-public
20 employees; and programs for both the insured and uninsured
21 funded by the Department of Human Services.

22 (d) An essential community behavioral health care provider
23 shall be compensated on a fee-for-service basis within a global
24 budget or within a risk-based incentive contract in accordance
25 with the contracts and standards of the respective payors.
26 Staff members and other health care providers in the service

1 area of the designated essential community behavioral health
2 care provider shall not be restricted from providing care,
3 treatment, or services through affiliation with any other
4 health insurer or health care service contractor.

5 (e) A designation of a community behavioral health care
6 provider as an essential community behavioral health care
7 provider shall end 5 years after the date the designation is
8 granted. The Department, however, may terminate the
9 designation for cause before the end of the 5-year period if
10 the essential community behavioral health care provider fails
11 to comply with the eligibility standards set forth in
12 subsection (b).

13 A designated essential community behavioral health care
14 provider may reapply for designation 6 months prior to the
15 designation ending and shall provide documented evidence that
16 the provider continues to meet all criteria for designation.

17 If the essential community behavioral health care provider
18 continues to meet all criteria for designation, the Department
19 shall continue the designation for an additional 5-year period.
20 (Source: P.A. 97-166, eff. 7-22-11.)

21 Section 10. The State Finance Act is amended by changing
22 Sections 6z-52, 6z-73, 6z-81, and 25 as follows:

23 (30 ILCS 105/6z-52)
24 Sec. 6z-52. Drug Rebate Fund.

1 (a) There is created in the State Treasury a special fund
2 to be known as the Drug Rebate Fund.
3 (b) The Fund is created for the purpose of receiving and
4 disbursing moneys in accordance with this Section.
5 Disbursements from the Fund shall be made, subject to
6 appropriation, only as follows:
7 (1) For payments for reimbursement or coverage for
8 prescription drugs and other pharmacy products provided to
9 a recipient of medical assistance under the Illinois Public
10 Aid Code, the Children's Health Insurance Program Act, the
11 Covering ALL KIDS and Young Adults Health Insurance Act,
12 and the Veterans' Health Insurance Program Act of 2008.
13 (1.5) For payments to managed care organizations as
14 defined in Section 5-30.1 of the Illinois Public Aid Code.
15 (2) For reimbursement of moneys collected by the
16 Department of Healthcare and Family Services (formerly
17 Illinois Department of Public Aid) through error or
18 mistake.
19 (3) For payments of any amounts that are reimbursable
20 to the federal government resulting from a payment into
21 this Fund.
22 (4) For payments of operational and administrative
23 expenses related to providing and managing coverage for
24 prescription drugs and other pharmacy products provided to
25 a recipient of medical assistance under the Illinois Public
26 Aid Code, the Children's Health Insurance Program Act, the

Covering ALL KIDS and Young Adults Health Insurance Act, and the Veterans' Health Insurance Program Act of 2008.

(c) The Fund shall consist of the following:

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

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

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

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

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

2 (30 ILCS 105/6z-73)
3 Sec. 6z-73. Financial Institutions Settlement of 2008
4 Fund. The Financial Institutions Settlement of 2008 Fund is
5 created as a nonappropriated trust fund to be held outside the
6 State treasury, with the State Treasurer as custodian. Moneys
7 in the Fund shall be used by the Comptroller solely for the
8 purpose of payment of outstanding vouchers as of the effective
9 date of this amendatory Act of the 95th General Assembly for
10 expenses related to medical assistance under the Illinois
11 Public Aid Code, the Children's Health Insurance Program Act,
12 the Covering ALL KIDS and Young Adults Health Insurance Act,
13 and the Senior Citizens and Disabled Persons Property Tax
14 Relief and Pharmaceutical Assistance Act. The Department of
15 Healthcare and Family Services must submit all necessary and
16 proper documentation to the Comptroller for administration of
17 this Fund.
18 (Source: P.A. 95-1047, eff. 4-6-09.)

19 (30 ILCS 105/6z-81)
20 Sec. 6z-81. Healthcare Provider Relief Fund.
21 (a) There is created in the State treasury a special fund
22 to be known as the Healthcare Provider Relief Fund.
23 (b) The Fund is created for the purpose of receiving and
24 disbursing moneys in accordance with this Section.

1 Disbursements from the Fund shall be made only as follows:
2 (1) Subject to appropriation, for payment by the
3 Department of Healthcare and Family Services or by the
4 Department of Human Services of medical bills and related
5 expenses, including administrative expenses, for which the
6 State is responsible under Titles XIX and XXI of the Social
7 Security Act, the Illinois Public Aid Code, the Children's
8 Health Insurance Program Act, the Covering ALL KIDS and
9 Young Adults Health Insurance Act, and the Long Term Acute
10 Care Hospital Quality Improvement Transfer Program Act.
11 (2) For repayment of funds borrowed from other State
12 funds or from outside sources, including interest thereon.
13 (3) For State fiscal years 2017, 2018, and 2019, for
14 making payments to the human poison control center pursuant
15 to Section 12-4.105 of the Illinois Public Aid Code.
16 (c) The Fund shall consist of the following:
17 (1) Moneys received by the State from short-term
18 borrowing pursuant to the Short Term Borrowing Act on or
19 after the effective date of Public Act 96-820.
20 (2) All federal matching funds received by the Illinois
21 Department of Healthcare and Family Services as a result of
22 expenditures made by the Department that are attributable
23 to moneys deposited in the Fund.
24 (3) All federal matching funds received by the Illinois
25 Department of Healthcare and Family Services as a result of
26 federal approval of Title XIX State plan amendment

1 transmittal number 07-09.
2 (4) All other moneys received for the Fund from any
3 other source, including interest earned thereon.
4 (5) All federal matching funds received by the Illinois
5 Department of Healthcare and Family Services as a result of
6 expenditures made by the Department for Medical Assistance
7 from the General Revenue Fund, the Tobacco Settlement
8 Recovery Fund, the Long-Term Care Provider Fund, and the
9 Drug Rebate Fund related to individuals eligible for
10 medical assistance pursuant to the Patient Protection and
11 Affordable Care Act (P.L. 111-148) and Section 5-2 of the
12 Illinois Public Aid Code.
13 (d) In addition to any other transfers that may be provided
14 for by law, on the effective date of Public Act 97-44, or as
15 soon thereafter as practical, the State Comptroller shall
16 direct and the State Treasurer shall transfer the sum of
17 $365,000,000 from the General Revenue Fund into the Healthcare
18 Provider Relief Fund.
19 (e) In addition to any other transfers that may be provided
20 for by law, on July 1, 2011, or as soon thereafter as
21 practical, the State Comptroller shall direct and the State
22 Treasurer shall transfer the sum of $160,000,000 from the
23 General Revenue Fund to the Healthcare Provider Relief Fund.
24 (f) Notwithstanding any other State law to the contrary,
25 and in addition to any other transfers that may be provided for
26 by law, the State Comptroller shall order transferred and the

1 State Treasurer shall transfer $500,000,000 to the Healthcare
2 Provider Relief Fund from the General Revenue Fund in equal
3 monthly installments of $100,000,000, with the first transfer
4 to be made on July 1, 2012, or as soon thereafter as practical,
5 and with each of the remaining transfers to be made on August
6 1, 2012, September 1, 2012, October 1, 2012, and November 1,
7 2012, or as soon thereafter as practical. This transfer may
8 assist the Department of Healthcare and Family Services in
9 improving Medical Assistance bill processing timeframes or in
10 meeting the possible requirements of Senate Bill 3397, or other
11 similar legislation, of the 97th General Assembly should it
12 become law.
13 (g) Notwithstanding any other State law to the contrary,
14 and in addition to any other transfers that may be provided for
15 by law, on July 1, 2013, or as soon thereafter as may be
16 practical, the State Comptroller shall direct and the State
17 Treasurer shall transfer the sum of $601,000,000 from the
18 General Revenue Fund to the Healthcare Provider Relief Fund.
19 (Source: P.A. 99-516, eff. 6-30-16; 100-587, eff. 6-4-18.)

20 (30 ILCS 105/25) (from Ch. 127, par. 161)
21 Sec. 25. Fiscal year limitations.
22 (a) All appropriations shall be available for expenditure
23 for the fiscal year or for a lesser period if the Act making
24 that appropriation so specifies. A deficiency or emergency
25 appropriation shall be available for expenditure only through

June 30 of the year when the Act making that appropriation is enacted unless that Act otherwise provides.

(b) Outstanding liabilities as of June 30, payable from appropriations which have otherwise expired, may be paid out of the expiring appropriations during the 2-month period ending at the close of business on August 31. Any service involving professional or artistic skills or any personal services by an employee whose compensation is subject to income tax withholding must be performed as of June 30 of the fiscal year in order to be considered an "outstanding liability as of June 30" that is thereby eligible for payment out of the expiring appropriation.

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

business on October 31.

(b-2) All outstanding liabilities as of June 30, 2010, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2010, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring appropriations until December 31, 2010, without regard to the fiscal year in which the payment is made, as long as vouchers for the liabilities are received by the Comptroller no later than August 31, 2010.

(b-2.5) All outstanding liabilities as of June 30, 2011, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2011, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring appropriations until December 31, 2011, without regard to the fiscal year in which the payment is made, as long as vouchers for the liabilities are received by the Comptroller no later than August 31, 2011.

(b-2.6) All outstanding liabilities as of June 30, 2012, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2012, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring appropriations until December 31, 2012, without regard to the fiscal year in which the payment is made, as long as vouchers

1 for the liabilities are received by the Comptroller no later
2 than August 31, 2012.
3 (b-2.6a) All outstanding liabilities as of June 30, 2017,
4 payable from appropriations that would otherwise expire at the
5 conclusion of the lapse period for fiscal year 2017, and
6 interest penalties payable on those liabilities under the State
7 Prompt Payment Act, may be paid out of the expiring
8 appropriations until December 31, 2017, without regard to the
9 fiscal year in which the payment is made, as long as vouchers
10 for the liabilities are received by the Comptroller no later
11 than September 30, 2017.
12 (b-2.6b) All outstanding liabilities as of June 30, 2018,
13 payable from appropriations that would otherwise expire at the
14 conclusion of the lapse period for fiscal year 2018, and
15 interest penalties payable on those liabilities under the State
16 Prompt Payment Act, may be paid out of the expiring
17 appropriations until December 31, 2018, without regard to the
18 fiscal year in which the payment is made, as long as vouchers
19 for the liabilities are received by the Comptroller no later
20 than October 31, 2018.
21 (b-2.7) For fiscal years 2012, 2013, and 2014, interest
22 penalties payable under the State Prompt Payment Act associated
23 with a voucher for which payment is issued after June 30 may be
24 paid out of the next fiscal year's appropriation. The future
25 year appropriation must be for the same purpose and from the
26 same fund as the original payment. An interest penalty voucher

1 submitted against a future year appropriation must be submitted
2 within 60 days after the issuance of the associated voucher,
3 and the Comptroller must issue the interest payment within 60
4 days after acceptance of the interest voucher.

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

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

1 made at the discretion of the Department of Healthcare and
2 Family Services (or successor agency) from the Health Insurance
3 Reserve Fund and payable from appropriations that have
4 otherwise expired may be paid out of the expiring appropriation
5 during the 4-month period ending at the close of business on
6 October 31.

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

22 (b-6) Additionally, payments may be made by the Department
23 of Human Services from its appropriations, or any other State
24 agency from its appropriations with the approval of the
25 Department of Human Services, from the Immigration Reform and
26 Control Fund for purposes authorized pursuant to the

1 Immigration Reform and Control Act of 1986, without regard to
2 any fiscal year limitations, except as required by subsection
3 (j) of this Section. Beginning on June 30, 2021, payments made
4 by the Department of Human Services from the Immigration Reform
5 and Control Fund for purposes authorized pursuant to the
6 Immigration Reform and Control Act of 1986 payable from
7 appropriations that have otherwise expired may be paid out of
8 the expiring appropriation during the 4-month period ending at
9 the close of business on October 31.

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

15 (b-8) Reimbursements to eligible airport sponsors for the
16 construction or upgrading of Automated Weather Observation
17 Systems may be made by the Department of Transportation from
18 appropriations for those purposes for any fiscal year, without
19 regard to the fact that the qualification or obligation may
20 have occurred in a prior fiscal year, provided that at the time
21 the expenditure was made the project had been approved by the
22 Department of Transportation prior to June 1, 2012 and, as a
23 result of recent changes in federal funding formulas, can no
24 longer receive federal reimbursement.

25 (b-9) Medical payments not exceeding $150,000,000 may be
26 made by the Department on Aging from its appropriations

relating to the Community Care Program for fiscal year 2014, without regard to the fact that the medical services being compensated for by such payment may have been rendered in a prior fiscal year, provided the payments are made on a fee-for-service basis consistent with requirements established for Medicaid reimbursement by the Department of Healthcare and Family Services, except as required by subsection (j) of this Section.

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

1 Children Nutrition Program payable from appropriations that
2 have otherwise expired may be paid out of the expiring
3 appropriations during the 4-month period ending at the close of
4 business on October 31.
5 (d) The Department of Public Health and the Department of
6 Human Services (acting as successor to the Department of Public
7 Health under the Department of Human Services Act) shall each
8 annually submit to the State Comptroller, Senate President,
9 Senate Minority Leader, Speaker of the House, House Minority
10 Leader, and the respective Chairmen and Minority Spokesmen of
11 the Appropriations Committees of the Senate and the House, on
12 or before December 31, a report of fiscal year funds used to
13 pay for services provided in any prior fiscal year. This report
14 shall document by program or service category those
15 expenditures from the most recently completed fiscal year used
16 to pay for services provided in prior fiscal years.
17 (e) The Department of Healthcare and Family Services, the
18 Department of Human Services (acting as successor to the
19 Department of Public Aid), and the Department of Human Services
20 making fee-for-service payments relating to substance abuse
21 treatment services provided during a previous fiscal year shall
22 each annually submit to the State Comptroller, Senate
23 President, Senate Minority Leader, Speaker of the House, House
24 Minority Leader, the respective Chairmen and Minority
25 Spokesmen of the Appropriations Committees of the Senate and
26 the House, on or before November 30, a report that shall

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

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

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

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

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

1 medical services.
2 (3) The results of the Department's efforts to combat
3 fraud and abuse.
4 (h) As provided in Section 4 of the General Assembly
5 Compensation Act, any utility bill for service provided to a
6 General Assembly member's district office for a period
7 including portions of 2 consecutive fiscal years may be paid
8 from funds appropriated for such expenditure in either fiscal
9 year.
10 (i) An agency which administers a fund classified by the
11 Comptroller as an internal service fund may issue rules for:
12 (1) billing user agencies in advance for payments or
13 authorized inter-fund transfers based on estimated charges
14 for goods or services;
15 (2) issuing credits, refunding through inter-fund
16 transfers, or reducing future inter-fund transfers during
17 the subsequent fiscal year for all user agency payments or
18 authorized inter-fund transfers received during the prior
19 fiscal year which were in excess of the final amounts owed
20 by the user agency for that period; and
21 (3) issuing catch-up billings to user agencies during
22 the subsequent fiscal year for amounts remaining due when
23 payments or authorized inter-fund transfers received from
24 the user agency during the prior fiscal year were less than
25 the total amount owed for that period.
26 User agencies are authorized to reimburse internal service

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

(i-1) Beginning on July 1, 2021, all outstanding liabilities, not payable during the 4-month lapse period as described in subsections (b-1), (b-3), (b-4), (b-5), (b-6), and (c) of this Section, that are made from appropriations for that purpose for any fiscal year, without regard to the fact that the services being compensated for by those payments may have been rendered in a prior fiscal year, are limited to only those claims that have been incurred but for which a proper bill or invoice as defined by the State Prompt Payment Act has not been received by September 30th following the end of the fiscal year in which the service was rendered.

(j) Notwithstanding any other provision of this Act, the aggregate amount of payments to be made without regard for fiscal year limitations as contained in subsections (b-1), (b-3), (b-4), (b-5), (b-6), and (c) of this Section, and determined by using Generally Accepted Accounting Principles, shall not exceed the following amounts:

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

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

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

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

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

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

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

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

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

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

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

(1) Definition of Medical Assistance.

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

1 Insurance Program Act, the Covering ALL KIDS and Young
2 Adults Health Insurance Act, the Long Term Acute Care
3 Hospital Quality Improvement Transfer Program Act, and
4 medical care to or on behalf of persons suffering from
5 chronic renal disease, persons suffering from
6 hemophilia, and victims of sexual assault.
7 (2) Limitations on Medical Assistance payments that
8 may be paid from future fiscal year appropriations.
9 (A) The maximum amounts of annual unpaid Medical
10 Assistance bills received and recorded by the
11 Department of Healthcare and Family Services on or
12 before June 30th of a particular fiscal year
13 attributable in aggregate to the General Revenue Fund,
14 Healthcare Provider Relief Fund, Tobacco Settlement
15 Recovery Fund, Long-Term Care Provider Fund, and the
16 Drug Rebate Fund that may be paid in total by the
17 Department from future fiscal year Medical Assistance
18 appropriations to those funds are: $700,000,000 for
19 fiscal year 2013 and $100,000,000 for fiscal year 2014
20 and each fiscal year thereafter.
21 (B) Bills for Medical Assistance services rendered
22 in a particular fiscal year, but received and recorded
23 by the Department of Healthcare and Family Services
24 after June 30th of that fiscal year, may be paid from
25 either appropriations for that fiscal year or future
26 fiscal year appropriations for Medical Assistance.

1 Such payments shall not be subject to the requirements
2 of subparagraph (A).
3 (C) Medical Assistance bills received by the
4 Department of Healthcare and Family Services in a
5 particular fiscal year, but subject to payment amount
6 adjustments in a future fiscal year may be paid from a
7 future fiscal year's appropriation for Medical
8 Assistance. Such payments shall not be subject to the
9 requirements of subparagraph (A).
10 (D) Medical Assistance payments made by the
11 Department of Healthcare and Family Services from
12 funds other than those specifically referenced in
13 subparagraph (A) may be made from appropriations for
14 those purposes for any fiscal year without regard to
15 the fact that the Medical Assistance services being
16 compensated for by such payment may have been rendered
17 in a prior fiscal year. Such payments shall not be
18 subject to the requirements of subparagraph (A).
19 (3) Extended lapse period for Department of Healthcare
20 and Family Services Medical Assistance payments.
21 Notwithstanding any other State law to the contrary,
22 outstanding Department of Healthcare and Family Services
23 Medical Assistance liabilities, as of June 30th, payable
24 from appropriations which have otherwise expired, may be
25 paid out of the expiring appropriations during the 6-month
26 period ending at the close of business on December 31st.

1 (l) The changes to this Section made by Public Act 97-691
2 shall be effective for payment of Medical Assistance bills
3 incurred in fiscal year 2013 and future fiscal years. The
4 changes to this Section made by Public Act 97-691 shall not be
5 applied to Medical Assistance bills incurred in fiscal year
6 2012 or prior fiscal years.
7 (m) The Comptroller must issue payments against
8 outstanding liabilities that were received prior to the lapse
9 period deadlines set forth in this Section as soon thereafter
10 as practical, but no payment may be issued after the 4 months
11 following the lapse period deadline without the signed
12 authorization of the Comptroller and the Governor.
13 (Source: P.A. 100-23, eff. 7-6-17; 100-587, eff. 6-4-18.)

14 Section 15. The State Prompt Payment Act is amended by
15 changing Section 3-2 as follows:

16 (30 ILCS 540/3-2)
17 Sec. 3-2. Beginning July 1, 1993, in any instance where a
18 State official or agency is late in payment of a vendor's bill
19 or invoice for goods or services furnished to the State, as
20 defined in Section 1, properly approved in accordance with
21 rules promulgated under Section 3-3, the State official or
22 agency shall pay interest to the vendor in accordance with the
23 following:
24 (1) Any bill, except a bill submitted under Article V

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

1 1.0% of any amount approved and unpaid shall be added for
2 each month or fraction thereof after the end of this 60-day
3 period, until final payment is made.
4 (1.05) For State fiscal year 2012 and future fiscal
5 years, any bill approved for payment under this Section
6 must be paid or the payment issued to the payee within 90
7 days of receipt of a proper bill or invoice. If payment is
8 not issued to the payee within this 90-day period, an
9 interest penalty of 1.0% of any amount approved and unpaid
10 shall be added for each month, or 0.033% (one-thirtieth of
11 one percent) of any amount approved and unpaid for each
12 day, after the end of this 90-day period, until final
13 payment is made.
14 (1.1) A State agency shall review in a timely manner
15 each bill or invoice after its receipt. If the State agency
16 determines that the bill or invoice contains a defect
17 making it unable to process the payment request, the agency
18 shall notify the vendor requesting payment as soon as
19 possible after discovering the defect pursuant to rules
20 promulgated under Section 3-3; provided, however, that the
21 notice for construction related bills or invoices must be
22 given not later than 30 days after the bill or invoice was
23 first submitted. The notice shall identify the defect and
24 any additional information necessary to correct the
25 defect. If one or more items on a construction related bill
26 or invoice are disapproved, but not the entire bill or

1 invoice, then the portion that is not disapproved shall be
2 paid.

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

24 (3) The provisions of Public Act 96-1501 reducing the
25 interest rate on pharmacy claims under Article V of the
26 Illinois Public Aid Code to 1.0% per month shall apply to

any pharmacy bills for services and goods under Article V of the Illinois Public Aid Code received on or after the date 60 days before January 25, 2011 (the effective date of Public Act 96-1501) except as provided under paragraph (1.05) of this Section.

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

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

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

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

(35 ILCS 105/3-8)

Sec. 3-8. Hospital exemption.

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

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

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

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

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

19 (2) Health services to low-income and underserved
20 individuals. Other unreimbursed costs of the relevant
21 hospital entity for providing without charge, paying for,
22 or subsidizing goods, activities, or services for the
23 purpose of addressing the health of low-income or
24 underserved individuals. Those activities or services may
25 include, but are not limited to: financial or in-kind
26 support to affiliated or unaffiliated hospitals, hospital

1 affiliates, community clinics, or programs that treat
2 low-income or underserved individuals; paying for or
3 subsidizing health care professionals who care for
4 low-income or underserved individuals; providing or
5 subsidizing outreach or educational services to low-income
6 or underserved individuals for disease management and
7 prevention; free or subsidized goods, supplies, or
8 services needed by low-income or underserved individuals
9 because of their medical condition; and prenatal or
10 childbirth outreach to low-income or underserved persons.
11 (3) Subsidy of State or local governments. Direct or
12 indirect financial or in-kind subsidies of State or local
13 governments by the relevant hospital entity that pay for or
14 subsidize activities or programs related to health care for
15 low-income or underserved individuals.
16 (4) Support for State health care programs for
17 low-income individuals. At the election of the hospital
18 applicant for each applicable year, either (A) 10% of
19 payments to the relevant hospital entity and any hospital
20 affiliate designated by the relevant hospital entity
21 (provided that such hospital affiliate's operations
22 provide financial or operational support for or receive
23 financial or operational support from the relevant
24 hospital entity) under Medicaid or other means-tested
25 programs, including, but not limited to, General
26 Assistance, the Covering ALL KIDS and Young Adults Health

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

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

multiplied by the cost to charge ratio taken from the hospital's most recently filed Medicare cost report (CMS 2252-10 Worksheet, Part I)) of patients treated in the relevant hospital entity's emergency department.

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

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

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

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

1 (2) the amount of unreimbursed costs and the amount of
2 subsidy shall not be reduced by restricted or unrestricted
3 payments received by the relevant hospital entity as
4 contributions deductible under Section 170(a) of the
5 Internal Revenue Code.
6 (f) (Blank).
7 (g) Estimation of Exempt Property Tax Liability. The
8 estimated property tax liability used for the determination in
9 subsection (b) shall be calculated as follows:
10 (1) "Estimated property tax liability" means the
11 estimated dollar amount of property tax that would be owed,
12 with respect to the exempt portion of each of the relevant
13 hospital entity's properties that are already fully or
14 partially exempt, or for which an exemption in whole or in
15 part is currently being sought, and then aggregated as
16 applicable, as if the exempt portion of those properties
17 were subject to tax, calculated with respect to each such
18 property by multiplying:
19 (A) the lesser of (i) the actual assessed value, if
20 any, of the portion of the property for which an
21 exemption is sought or (ii) an estimated assessed value
22 of the exempt portion of such property as determined in
23 item (2) of this subsection (g), by
24 (B) the applicable State equalization rate
25 (yielding the equalized assessed value), by
26 (C) the applicable tax rate.

1 (2) The estimated assessed value of the exempt portion
2 of the property equals the sum of (i) the estimated fair
3 market value of buildings on the property, as determined in
4 accordance with subparagraphs (A) and (B) of this item (2),
5 multiplied by the applicable assessment factor, and (ii)
6 the estimated assessed value of the land portion of the
7 property, as determined in accordance with subparagraph
8 (C).
9 (A) The "estimated fair market value of buildings
10 on the property" means the replacement value of any
11 exempt portion of buildings on the property, minus
12 depreciation, determined utilizing the cost
13 replacement method whereby the exempt square footage
14 of all such buildings is multiplied by the replacement
15 cost per square foot for Class A Average building found
16 in the most recent edition of the Marshall & Swift
17 Valuation Services Manual, adjusted by any appropriate
18 current cost and local multipliers.
19 (B) Depreciation, for purposes of calculating the
20 estimated fair market value of buildings on the
21 property, is applied by utilizing a weighted mean life
22 for the buildings based on original construction and
23 assuming a 40-year life for hospital buildings and the
24 applicable life for other types of buildings as
25 specified in the American Hospital Association
26 publication "Estimated Useful Lives of Depreciable

1 Hospital Assets". In the case of hospital buildings,
2 the remaining life is divided by 40 and this ratio is
3 multiplied by the replacement cost of the buildings to
4 obtain an estimated fair market value of buildings. If
5 a hospital building is older than 35 years, a remaining
6 life of 5 years for residual value is assumed; and if a
7 building is less than 8 years old, a remaining life of
8 32 years is assumed.
9 (C) The estimated assessed value of the land
10 portion of the property shall be determined by
11 multiplying (i) the per square foot average of the
12 assessed values of three parcels of land (not including
13 farm land, and excluding the assessed value of the
14 improvements thereon) reasonably comparable to the
15 property, by (ii) the number of square feet comprising
16 the exempt portion of the property's land square
17 footage.
18 (3) The assessment factor, State equalization rate,
19 and tax rate (including any special factors such as
20 Enterprise Zones) used in calculating the estimated
21 property tax liability shall be for the most recent year
22 that is publicly available from the applicable chief county
23 assessment officer or officers at least 90 days before the
24 end of the hospital year.
25 (4) The method utilized to calculate estimated
26 property tax liability for purposes of this Section 15-86

shall not be utilized for the actual valuation, assessment, or taxation of property pursuant to the Property Tax Code.

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

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

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

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

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

(5) "Control" relating to hospital owners, hospital affiliates, or hospital systems means possession, direct

or indirect, of the power to direct or cause the direction of the management and policies of the entity, whether through ownership of assets, membership interest, other voting or governance rights, by contract or otherwise.

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

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

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

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

(Source: P.A. 98-463, eff. 8-16-13; 99-143, eff. 7-27-15.)

Section 25. The Retailers' Occupation Tax Act is amended by

1 changing Section 2-9 as follows:

2 (35 ILCS 120/2-9)
3 Sec. 2-9. Hospital exemption.
4 (a) Tangible personal property sold to or used by a
5 hospital owner that owns one or more hospitals licensed under
6 the Hospital Licensing Act or operated under the University of
7 Illinois Hospital Act, or a hospital affiliate that is not
8 already exempt under another provision of this Act and meets
9 the criteria for an exemption under this Section, is exempt
10 from taxation under this Act.
11 (b) A hospital owner or hospital affiliate satisfies the
12 conditions for an exemption under this Section if the value of
13 qualified services or activities listed in subsection (c) of
14 this Section for the hospital year equals or exceeds the
15 relevant hospital entity's estimated property tax liability,
16 without regard to any property tax exemption granted under
17 Section 15-86 of the Property Tax Code, for the calendar year
18 in which exemption or renewal of exemption is sought. For
19 purposes of making the calculations required by this subsection
20 (b), if the relevant hospital entity is a hospital owner that
21 owns more than one hospital, the value of the services or
22 activities listed in subsection (c) shall be calculated on the
23 basis of only those services and activities relating to the
24 hospital that includes the subject property, and the relevant
25 hospital entity's estimated property tax liability shall be

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

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

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

17 (2) Health services to low-income and underserved
18 individuals. Other unreimbursed costs of the relevant
19 hospital entity for providing without charge, paying for,
20 or subsidizing goods, activities, or services for the
21 purpose of addressing the health of low-income or
22 underserved individuals. Those activities or services may
23 include, but are not limited to: financial or in-kind
24 support to affiliated or unaffiliated hospitals, hospital
25 affiliates, community clinics, or programs that treat
26 low-income or underserved individuals; paying for or

subsidizing health care professionals who care for low-income or underserved individuals; providing or subsidizing outreach or educational services to low-income or underserved individuals for disease management and prevention; free or subsidized goods, supplies, or services needed by low-income or underserved individuals because of their medical condition; and prenatal or childbirth outreach to low-income or underserved persons.

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

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

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

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

2252-10 Worksheet, Part I)) of patients treated in the relevant hospital entity's emergency department.

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

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

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

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

(2) the amount of unreimbursed costs and the amount of subsidy shall not be reduced by restricted or unrestricted

1 payments received by the relevant hospital entity as
2 contributions deductible under Section 170(a) of the
3 Internal Revenue Code.
4 (f) (Blank).
5 (g) Estimation of Exempt Property Tax Liability. The
6 estimated property tax liability used for the determination in
7 subsection (b) shall be calculated as follows:
8 (1) "Estimated property tax liability" means the
9 estimated dollar amount of property tax that would be owed,
10 with respect to the exempt portion of each of the relevant
11 hospital entity's properties that are already fully or
12 partially exempt, or for which an exemption in whole or in
13 part is currently being sought, and then aggregated as
14 applicable, as if the exempt portion of those properties
15 were subject to tax, calculated with respect to each such
16 property by multiplying:
17 (A) the lesser of (i) the actual assessed value, if
18 any, of the portion of the property for which an
19 exemption is sought or (ii) an estimated assessed value
20 of the exempt portion of such property as determined in
21 item (2) of this subsection (g), by
22 (B) the applicable State equalization rate
23 (yielding the equalized assessed value), by
24 (C) the applicable tax rate.
25 (2) The estimated assessed value of the exempt portion
26 of the property equals the sum of (i) the estimated fair

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

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

(B) Depreciation, for purposes of calculating the estimated fair market value of buildings on the property, is applied by utilizing a weighted mean life for the buildings based on original construction and assuming a 40-year life for hospital buildings and the applicable life for other types of buildings as specified in the American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets". In the case of hospital buildings, the remaining life is divided by 40 and this ratio is

1 multiplied by the replacement cost of the buildings to
2 obtain an estimated fair market value of buildings. If
3 a hospital building is older than 35 years, a remaining
4 life of 5 years for residual value is assumed; and if a
5 building is less than 8 years old, a remaining life of
6 32 years is assumed.

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

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

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

1 (h) For the purpose of this Section, the following terms
2 shall have the meanings set forth below:
3 (1) "Hospital" means any institution, place, building,
4 buildings on a campus, or other health care facility
5 located in Illinois that is licensed under the Hospital
6 Licensing Act and has a hospital owner.
7 (2) "Hospital owner" means a not-for-profit
8 corporation that is the titleholder of a hospital, or the
9 owner of the beneficial interest in an Illinois land trust
10 that is the titleholder of a hospital.
11 (3) "Hospital affiliate" means any corporation,
12 partnership, limited partnership, joint venture, limited
13 liability company, association or other organization,
14 other than a hospital owner, that directly or indirectly
15 controls, is controlled by, or is under common control with
16 one or more hospital owners and that supports, is supported
17 by, or acts in furtherance of the exempt health care
18 purposes of at least one of those hospital owners'
19 hospitals.
20 (4) "Hospital system" means a hospital and one or more
21 other hospitals or hospital affiliates related by common
22 control or ownership.
23 (5) "Control" relating to hospital owners, hospital
24 affiliates, or hospital systems means possession, direct
25 or indirect, of the power to direct or cause the direction
26 of the management and policies of the entity, whether

through ownership of assets, membership interest, other voting or governance rights, by contract or otherwise.

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

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

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

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

(Source: P.A. 98-463, eff. 8-16-13; 99-143, eff. 7-27-15.)

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

(35 ILCS 200/15-86)

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

(a) The General Assembly finds:

(1) Despite the Supreme Court's decision in *Provena Covenant Medical Center v. Dept. of Revenue*, 236 Ill.2d 368, there is considerable uncertainty surrounding the test for charitable property tax exemption, especially regarding the application of a quantitative or monetary threshold. In *Provena*, the Department stated that the primary basis for its decision was the hospital's inadequate amount of charitable activity, but the Department has not articulated what constitutes an adequate amount of charitable activity. After *Provena*, the Department denied property tax exemption applications of 3 more hospitals, and, on the effective date of this amendatory Act of the 97th General Assembly, at least 20 other hospitals are awaiting rulings on applications for property tax exemption.

(2) In *Provena*, two Illinois Supreme Court justices opined that "setting a monetary or quantum standard is a complex decision which should be left to our legislature, should it so choose". The Appellate Court in *Provena* stated: "The language we use in the State of Illinois to determine whether real property is used for a charitable

1 purpose has its genesis in our 1870 Constitution. It is
2 obvious that such language may be difficult to apply to the
3 modern face of our nation's health care delivery systems".
4 The court noted the many significant changes in the health
5 care system since that time, but concluded that taking
6 these changes into account is a matter of public policy,
7 and "it is the legislature's job, not ours, to make public
8 policy".

9 (3) It is essential to ensure that tax exemption law
10 relating to hospitals accounts for the complexities of the
11 modern health care delivery system. Health care is moving
12 beyond the walls of the hospital. In addition to treating
13 individual patients, hospitals are assuming responsibility
14 for improving the health status of communities and
15 populations. Low-income and underserved communities
16 benefit disproportionately by these activities.

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

1 participation and partnership of Illinois hospitals.
2 (5) Working with the Illinois hospital community and
3 other interested parties, the General Assembly has
4 developed a comprehensive combination of related
5 legislation that addresses hospital property tax
6 exemption, significantly increases access to free health
7 care for indigent persons, and strengthens the Medical
8 Assistance program. It is the intent of the General
9 Assembly to establish a new category of ownership for
10 charitable property tax exemption to be applied to
11 not-for-profit hospitals and hospital affiliates in lieu
12 of the existing ownership category of "institutions of
13 public charity". It is also the intent of the General
14 Assembly to establish quantifiable standards for the
15 issuance of charitable exemptions for such property. It is
16 not the intent of the General Assembly to declare any
17 property exempt ipso facto, but rather to establish
18 criteria to be applied to the facts on a case-by-case
19 basis.
20 (b) For the purpose of this Section and Section 15-10, the
21 following terms shall have the meanings set forth below:
22 (1) "Hospital" means any institution, place, building,
23 buildings on a campus, or other health care facility
24 located in Illinois that is licensed under the Hospital
25 Licensing Act and has a hospital owner.
26 (2) "Hospital owner" means a not-for-profit

1 corporation that is the titleholder of a hospital, or the
2 owner of the beneficial interest in an Illinois land trust
3 that is the titleholder of a hospital.

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

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

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

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

25 (7) "Relevant hospital entity" means (A) the hospital
26 owner, in the case of a hospital applicant that is a

1 hospital owner, and (B) at the election of a hospital
2 applicant that is a hospital affiliate, either (i) the
3 hospital affiliate or (ii) the hospital system to which the
4 hospital applicant belongs, including any hospitals or
5 hospital affiliates that are related by common control or
6 ownership.

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

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

16 (c) A hospital applicant satisfies the conditions for an
17 exemption under this Section with respect to the subject
18 property, and shall be issued a charitable exemption for that
19 property, if the value of services or activities listed in
20 subsection (e) for the hospital year equals or exceeds the
21 relevant hospital entity's estimated property tax liability,
22 as determined under subsection (g), for the year for which
23 exemption is sought. For purposes of making the calculations
24 required by this subsection (c), if the relevant hospital
25 entity is a hospital owner that owns more than one hospital,
26 the value of the services or activities listed in subsection

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

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

23 (d) The hospital applicant shall include information in its
24 exemption application establishing that it satisfies the
25 requirements of subsection (c). For purposes of making the
26 calculations required by subsection (c), the hospital

1 applicant may for each year elect to use either (1) the value
2 of the services or activities listed in subsection (e) for the
3 hospital year or (2) the average value of those services or
4 activities for the 3 fiscal years ending with the hospital
5 year. If the relevant hospital entity has been in operation for
6 less than 3 completed fiscal years, then the latter
7 calculation, if elected, shall be performed on a pro rata
8 basis.

9 (e) Services that address the health care needs of
10 low-income or underserved individuals or relieve the burden of
11 government with regard to health care services. The following
12 services and activities shall be considered for purposes of
13 making the calculations required by subsection (c):

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

19 (2) Health services to low-income and underserved
20 individuals. Other unreimbursed costs of the relevant
21 hospital entity for providing without charge, paying for,
22 or subsidizing goods, activities, or services for the
23 purpose of addressing the health of low-income or
24 underserved individuals. Those activities or services may
25 include, but are not limited to: financial or in-kind
26 support to affiliated or unaffiliated hospitals, hospital

1 affiliates, community clinics, or programs that treat
2 low-income or underserved individuals; paying for or
3 subsidizing health care professionals who care for
4 low-income or underserved individuals; providing or
5 subsidizing outreach or educational services to low-income
6 or underserved individuals for disease management and
7 prevention; free or subsidized goods, supplies, or
8 services needed by low-income or underserved individuals
9 because of their medical condition; and prenatal or
10 childbirth outreach to low-income or underserved persons.
11 (3) Subsidy of State or local governments. Direct or
12 indirect financial or in-kind subsidies of State or local
13 governments by the relevant hospital entity that pay for or
14 subsidize activities or programs related to health care for
15 low-income or underserved individuals.
16 (4) Support for State health care programs for
17 low-income individuals. At the election of the hospital
18 applicant for each applicable year, either (A) 10% of
19 payments to the relevant hospital entity and any hospital
20 affiliate designated by the relevant hospital entity
21 (provided that such hospital affiliate's operations
22 provide financial or operational support for or receive
23 financial or operational support from the relevant
24 hospital entity) under Medicaid or other means-tested
25 programs, including, but not limited to, General
26 Assistance, the Covering ALL KIDS <u>and Young Adults</u> Health

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

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

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

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

1 by multiplying gross charges by the cost to charge ratio
2 taken from the hospitals' most recently filed Medicare cost
3 report (CMS 2252-10 Worksheet C, Part I). In the case of
4 emergency services, the ratio shall be calculated using
5 costs (gross charges multiplied by the cost to charge ratio
6 taken from the hospitals' most recently filed Medicare cost
7 report (CMS 2252-10 Worksheet C, Part I)) of patients
8 treated in the relevant hospital entity's emergency
9 department.
10 (7) Any other activity by the relevant hospital entity
11 that the Department determines relieves the burden of
12 government or addresses the health of low-income or
13 underserved individuals.
14 (f) For purposes of making the calculations required by
15 subsections (c) and (e):
16 (1) particular services or activities eligible for
17 consideration under any of the paragraphs (1) through (7)
18 of subsection (e) may not be counted under more than one of
19 those paragraphs; and
20 (2) the amount of unreimbursed costs and the amount of
21 subsidy shall not be reduced by restricted or unrestricted
22 payments received by the relevant hospital entity as
23 contributions deductible under Section 170(a) of the
24 Internal Revenue Code.
25 (g) Estimation of Exempt Property Tax Liability. The
26 estimated property tax liability used for the determination in

1 subsection (c) shall be calculated as follows:
2 (1) "Estimated property tax liability" means the
3 estimated dollar amount of property tax that would be owed,
4 with respect to the exempt portion of each of the relevant
5 hospital entity's properties that are already fully or
6 partially exempt, or for which an exemption in whole or in
7 part is currently being sought, and then aggregated as
8 applicable, as if the exempt portion of those properties
9 were subject to tax, calculated with respect to each such
10 property by multiplying:
11 (A) the lesser of (i) the actual assessed value, if
12 any, of the portion of the property for which an
13 exemption is sought or (ii) an estimated assessed value
14 of the exempt portion of such property as determined in
15 item (2) of this subsection (g), by:
16 (B) the applicable State equalization rate
17 (yielding the equalized assessed value), by
18 (C) the applicable tax rate.
19 (2) The estimated assessed value of the exempt portion
20 of the property equals the sum of (i) the estimated fair
21 market value of buildings on the property, as determined in
22 accordance with subparagraphs (A) and (B) of this item (2),
23 multiplied by the applicable assessment factor, and (ii)
24 the estimated assessed value of the land portion of the
25 property, as determined in accordance with subparagraph
26 (C).

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

11 (B) Depreciation, for purposes of calculating the
12 estimated fair market value of buildings on the
13 property, is applied by utilizing a weighted mean life
14 for the buildings based on original construction and
15 assuming a 40-year life for hospital buildings and the
16 applicable life for other types of buildings as
17 specified in the American Hospital Association
18 publication "Estimated Useful Lives of Depreciable
19 Hospital Assets". In the case of hospital buildings,
20 the remaining life is divided by 40 and this ratio is
21 multiplied by the replacement cost of the buildings to
22 obtain an estimated fair market value of buildings. If
23 a hospital building is older than 35 years, a remaining
24 life of 5 years for residual value is assumed; and if a
25 building is less than 8 years old, a remaining life of
26 32 years is assumed.

1 (C) The estimated assessed value of the land
2 portion of the property shall be determined by
3 multiplying (i) the per square foot average of the
4 assessed values of three parcels of land (not including
5 farm land, and excluding the assessed value of the
6 improvements thereon) reasonably comparable to the
7 property, by (ii) the number of square feet comprising
8 the exempt portion of the property's land square
9 footage.
10 (3) The assessment factor, State equalization rate,
11 and tax rate (including any special factors such as
12 Enterprise Zones) used in calculating the estimated
13 property tax liability shall be for the most recent year
14 that is publicly available from the applicable chief county
15 assessment officer or officers at least 90 days before the
16 end of the hospital year.
17 (4) The method utilized to calculate estimated
18 property tax liability for purposes of this Section 15-86
19 shall not be utilized for the actual valuation, assessment,
20 or taxation of property pursuant to the Property Tax Code.
21 (h) Application. Each hospital applicant applying for a
22 property tax exemption pursuant to Section 15-5 and this
23 Section shall use an application form provided by the
24 Department. The application form shall specify the records
25 required in support of the application and those records shall
26 be submitted to the Department with the application form. Each

1 application or affidavit shall contain a verification by the
2 Chief Executive Officer of the hospital applicant under oath or
3 affirmation stating that each statement in the application or
4 affidavit and each document submitted with the application or
5 affidavit are true and correct. The records submitted with the
6 application pursuant to this Section shall include an exhibit
7 prepared by the relevant hospital entity showing (A) the value
8 of the relevant hospital entity's services and activities, if
9 any, under paragraphs (1) through (7) of subsection (e) of this
10 Section stated separately for each paragraph, and (B) the value
11 relating to the relevant hospital entity's estimated property
12 tax liability under subsections (g)(1)(A), (B), and (C),
13 subsections (g)(2)(A), (B), and (C), and subsection (g)(3) of
14 this Section stated separately for each item. Such exhibit will
15 be made available to the public by the chief county assessment
16 officer. Nothing in this Section shall be construed as limiting
17 the Attorney General's authority under the Illinois False
18 Claims Act.

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

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

25 Section 35. The Illinois Pension Code is amended by

1 changing Section 24-102 as follows:

2 (40 ILCS 5/24-102) (from Ch. 108 1/2, par. 24-102)
3 Sec. 24-102. As used in this Article, "employee" means any
4 person, including a person elected, appointed or under
5 contract, receiving compensation from the State or a unit of
6 local government or school district for personal services
7 rendered, including salaried persons. A health care provider
8 who elects to participate in the State Employees Deferred
9 Compensation Plan established under Section 24-104 of this Code
10 shall, for purposes of that participation, be deemed an
11 "employee" as defined in this Section.
12 As used in this Article, "health care provider" means a
13 dentist, physician, optometrist, pharmacist, or podiatric
14 physician that participates and receives compensation as a
15 provider under the Illinois Public Aid Code, the Children's
16 Health Insurance Act, or the Covering ALL KIDS and Young Adults
17 Health Insurance Act.
18 As used in this Article, "compensation" includes
19 compensation received in a lump sum for accumulated unused
20 vacation, personal leave or sick leave, with the exception of
21 health care providers. "Compensation" with respect to health
22 care providers is defined under the Illinois Public Aid Code,
23 the Children's Health Insurance Act, or the Covering ALL KIDS
24 Health Insurance Act.
25 Where applicable, in no event shall the total of the amount

1 of deferred compensation of an employee set aside in relation
2 to a particular year under the Illinois State Employees
3 Deferred Compensation Plan and the employee's nondeferred
4 compensation for that year exceed the total annual salary or
5 compensation under the existing salary schedule or
6 classification plan applicable to such employee in such year;
7 except that any compensation received in a lump sum for
8 accumulated unused vacation, personal leave or sick leave shall
9 not be included in the calculation of such totals.
10 (Source: P.A. 98-214, eff. 8-9-13.)

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

13 (110 ILCS 948/10)
14 Sec. 10. Definitions. In this Act, unless the context
15 otherwise requires:
16 "Dental hygienist" means a person who holds a license under
17 the Illinois Dental Practice Act to perform dental services as
18 authorized by Section 18 of the Illinois Dental Practice Act.
19 "Dental payments" means compensation provided to dentists
20 and dental specialists for services rendered under Article V of
21 the Illinois Public Aid Code, the Covering ALL KIDS and Young
22 Adults Health Insurance Act, or the Children's Health Insurance
23 Program Act.
24 "Dental specialist" means a person who has received a

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

"Dentist" means a person who has received a general license pursuant to paragraph (a) of Section 11 of the Illinois Dental Practice Act, who may perform any intraoral and extraoral procedure required in the practice of dentistry, and to whom is reserved the responsibilities specified in Section 17 of the Illinois Dental Practice Act.

"Department" means the Department of Public Health.

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

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

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

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

(110 ILCS 948/25)

Sec. 25. Eligibility. To be eligible for assistance under

the program, an applicant must meet all of the following qualifications:

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

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

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

(4) He or she must currently be repaying educational loans.

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

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

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

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

(110 ILCS 948/30)

Sec. 30. The award of grants.

(a) Under the program, for each year that a qualified applicant practices full time in this State in a designated shortage area as a dentist or dental specialist, the Department shall, subject to appropriation, award a grant to that person

in an amount equal to the amount in educational loans that the person must repay that year. However, the total amount in grants that a person may be awarded under the program must not exceed $25,000 per year for a 4-year period.

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

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

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

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

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

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

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

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

(3) Dentist willing to practice in a designated shortage area with the highest HPSA score and agreeing to allocate the highest percentage of patient appointments to those that are covered by Article V of the Illinois Public Aid Code, the Covering ALL KIDS and Young Adults Health Insurance Act, or the Children's Health Insurance Program Act.

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

Section 45. The Children's Health Insurance Program Act is amended by changing Section 23 as follows:

(215 ILCS 106/23)

Sec. 23. Care coordination.

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

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

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

1 arrangements.
2 (c) To qualify for compliance with this Section, the 50%
3 goal shall be achieved by enrolling medical assistance
4 enrollees from each medical assistance enrollment category,
5 including parents, children, seniors, and people with
6 disabilities to the extent that current State Medicaid payment
7 laws would not limit federal matching funds for recipients in
8 care coordination programs. In addition, services must be more
9 comprehensively defined and more risk shall be assumed than in
10 the Department's primary care case management program as of the
11 effective date of this amendatory Act of the 96th General
12 Assembly.
13 (d) The Department shall report to the General Assembly in
14 a separate part of its annual medical assistance program
15 report, beginning April, 2012 until April, 2016, on the
16 progress and implementation of the care coordination program
17 initiatives established by the provisions of this amendatory
18 Act of the 96th General Assembly. The Department shall include
19 in its April 2011 report a full analysis of federal laws or
20 regulations regarding upper payment limitations to providers
21 and the necessary revisions or adjustments in rate
22 methodologies and payments to providers under this Code that
23 would be necessary to implement coordinated care with full
24 financial risk by a party other than the Department.
25 (Source: P.A. 96-1501, eff. 1-25-11.)

1 Section 50. The Covering ALL KIDS Health Insurance Act is
2 amended by changing Sections 1, 5, 10, 15, 20, 25, 35, 40, 45,
3 47, and 56 as follows:

4 (215 ILCS 170/1)
5 (Section scheduled to be repealed on October 1, 2019)
6 Sec. 1. Short title. This Act may be cited as the Covering
7 ALL KIDS and Young Adults Health Insurance Act.
8 (Source: P.A. 94-693, eff. 7-1-06.)

9 (215 ILCS 170/5)
10 (Section scheduled to be repealed on October 1, 2019)
11 Sec. 5. Legislative intent. The General Assembly finds
12 that, for the economic and social benefit of all residents of
13 the State, it is important to enable all children and young
14 adults of this State to access affordable health insurance that
15 offers comprehensive coverage and emphasizes preventive
16 healthcare. Many children and young adults in working families,
17 including many families whose family income ranges between
18 $40,000 and $80,000, are uninsured. Numerous studies,
19 including the Institute of Medicine's report, "Health
20 Insurance Matters", demonstrate that lack of insurance
21 negatively affects health status. The General Assembly further
22 finds that access to healthcare is a key component for
23 children's and young adults' healthy development and
24 successful education. The effects of lack of insurance also

1 negatively impact those who are insured because the cost of
2 paying for care to the uninsured is often shifted to those who
3 have insurance in the form of higher health insurance premiums.
4 A Families USA 2005 report indicates that family premiums in
5 Illinois are increased by $1,059 due to cost-shifting from the
6 uninsured. It is, therefore, the intent of this legislation to
7 provide access to affordable health insurance to all uninsured
8 children and young adults in Illinois.
9 (Source: P.A. 94-693, eff. 7-1-06.)

10 (215 ILCS 170/10)
11 (Section scheduled to be repealed on October 1, 2019)
12 Sec. 10. Definitions. In this Act:
13 "Application agent" means an organization or individual,
14 such as a licensed health care provider, school, youth service
15 agency, employer, labor union, local chamber of commerce,
16 community-based organization, or other organization, approved
17 by the Department to assist in enrolling children and young
18 adults in the Program.
19 "Child" means a person under the age of 19.
20 "Young adult" means a person age 19 to 26.
21 "Department" means the Department of Healthcare and Family
22 Services.
23 "Medical assistance" means health care benefits provided
24 under Article V of the Illinois Public Aid Code.
25 "Program" means the Covering ALL KIDS and Young Adults

1 Health Insurance Program.
2 "Resident" means an individual (i) who is in the State for
3 other than a temporary or transitory purpose during the taxable
4 year or (ii) who is domiciled in this State but is absent from
5 the State for a temporary or transitory purpose during the
6 taxable year.
7 (Source: P.A. 94-693, eff. 7-1-06.)

8 (215 ILCS 170/15)
9 (Section scheduled to be repealed on October 1, 2019)
10 Sec. 15. Operation of Program. The Covering ALL KIDS and
11 Young Adults Health Insurance Program is created. The Program
12 shall be administered by the Department of Healthcare and
13 Family Services. The Department shall have the same powers and
14 authority to administer the Program as are provided to the
15 Department in connection with the Department's administration
16 of the Illinois Public Aid Code, including, but not limited to,
17 the provisions under Section 11-5.1 of the Code, and the
18 Children's Health Insurance Program Act. The Department shall
19 coordinate the Program with the existing children's health
20 programs operated by the Department and other State agencies.
21 Effective October 1, 2013, the determination of eligibility
22 under this Act shall comply with the requirements of 42 U.S.C.
23 1397bb(b)(1)(B)(v) and applicable federal regulations. If
24 changes made to this Section require federal approval, they
25 shall not take effect until such approval has been received.

1 (Source: P.A. 98-104, eff. 7-22-13.)

2 (215 ILCS 170/20)
3 (Section scheduled to be repealed on October 1, 2019)
4 Sec. 20. Eligibility.
5 (a) To be eligible for the Program, a person must be a
6 child <u>or young adult</u>:
7 (1) who is a resident of the State of Illinois;
8 (2) who is ineligible for medical assistance under the
9 Illinois Public Aid Code or benefits under the Children's
10 Health Insurance Program Act;
11 (3) who (i) effective July 1, 2014, in accordance with
12 42 CFR 457.805 (78 FR 42313, July 15, 2013) or any other
13 federal requirement necessary to obtain federal financial
14 participation for expenditures made under this Act, has
15 been without health insurance coverage for 90 days; (ii) is
16 a newborn whose responsible relative does not have
17 available affordable private or employer-sponsored health
18 insurance; or (iii) within one year of applying for
19 coverage under this Act, lost medical benefits under the
20 Illinois Public Aid Code or the Children's Health Insurance
21 Program Act; and
22 (3.5) whose household income, as determined, effective
23 October 1, 2013, by the Department, is at or below 300% of
24 the federal poverty level as determined in compliance with
25 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal

1 regulations.

2 An entity that provides health insurance coverage (as
3 defined in Section 2 of the Comprehensive Health Insurance Plan
4 Act) to Illinois residents shall provide health insurance data
5 match to the Department of Healthcare and Family Services as
6 provided by and subject to Section 5.5 of the Illinois
7 Insurance Code. The Department of Healthcare and Family
8 Services may impose an administrative penalty as provided under
9 Section 12-4.45 of the Illinois Public Aid Code on entities
10 that have established a pattern of failure to provide the
11 information required under this Section.

12 The Department of Healthcare and Family Services, in
13 collaboration with the Department of Insurance, shall adopt
14 rules governing the exchange of information under this Section.
15 The rules shall be consistent with all laws relating to the
16 confidentiality or privacy of personal information or medical
17 records, including provisions under the Federal Health
18 Insurance Portability and Accountability Act (HIPAA).

19 (b) The Department shall monitor the availability and
20 retention of employer-sponsored dependent health insurance
21 coverage and shall modify the period described in subdivision
22 (a)(3) if necessary to promote retention of private or
23 employer-sponsored health insurance and timely access to
24 healthcare services, but at no time shall the period described
25 in subdivision (a)(3) be less than 6 months.

26 (c) The Department, at its discretion, may take into

1 account the affordability of dependent health insurance when
2 determining whether employer-sponsored dependent health
3 insurance coverage is available upon reemployment of a child's
4 parent as provided in subdivision (a)(3).
5 (d) A child or young adult who is determined to be eligible
6 for the Program shall remain eligible for 12 months, provided
7 that the child or young adult maintains his or her residence in
8 this State, has not yet attained 26 ~~19~~ years of age, and is not
9 excluded under subsection (e).
10 (e) A child or young adult is not eligible for coverage
11 under the Program if:
12 (1) the premium required under Section 40 has not been
13 timely paid; if the required premiums are not paid, the
14 liability of the Program shall be limited to benefits
15 incurred under the Program for the time period for which
16 premiums have been paid; re-enrollment shall be completed
17 before the next covered medical visit, and the first
18 month's required premium shall be paid in advance of the
19 next covered medical visit; or
20 (2) the child or young adult is an inmate of a public
21 institution or an institution for mental diseases.
22 (f) The Department may adopt rules, including, but not
23 limited to: rules regarding annual renewals of eligibility for
24 the Program in conformance with Section 7 of this Act; rules
25 providing for re-enrollment, grace periods, notice
26 requirements, and hearing procedures under subdivision (e)(1)

of this Section; and rules regarding what constitutes availability and affordability of private or employer-sponsored health insurance, with consideration of such factors as the percentage of income needed to purchase children or family health insurance, the availability of employer subsidies, and other relevant factors.

(g) Each child enrolled in the Program as of July 1, 2011 whose family income, as established by the Department, exceeds 300% of the federal poverty level may remain enrolled in the Program for 12 additional months commencing July 1, 2011. Continued enrollment pursuant to this subsection shall be available only if the child continues to meet all eligibility criteria established under the Program as of the effective date of this amendatory Act of the 96th General Assembly without a break in coverage. Nothing contained in this subsection shall prevent a child from qualifying for any other health benefits program operated by the Department.

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

(215 ILCS 170/25)

(Section scheduled to be repealed on October 1, 2019)

Sec. 25. Enrollment in Program. The Department shall develop procedures to allow application agents to assist in enrolling children and young adults in the Program or other children's health programs operated by the Department. At the Department's discretion, technical assistance payments may be

1 made available for approved applications facilitated by an
2 application agent. The Department shall permit day and
3 temporary labor service agencies, as defined in the Day and
4 Temporary Labor Services Act and doing business in Illinois, to
5 enroll as unpaid application agents. As established in the Free
6 Healthcare Benefits Application Assistance Act, it shall be
7 unlawful for any person to charge another person or family for
8 assisting in completing and submitting an application for
9 enrollment in this Program.
10 (Source: P.A. 96-326, eff. 8-11-09.)

11 (215 ILCS 170/35)
12 (Section scheduled to be repealed on October 1, 2019)
13 Sec. 35. Health care benefits for children.
14 (a) The Department shall purchase or provide health care
15 benefits for eligible children that are identical to the
16 benefits provided for children under the Illinois Children's
17 Health Insurance Program Act, except for non-emergency
18 transportation. The Department shall purchase or provide
19 health care benefits for eligible young adults that are
20 identical to the benefits provided for individuals under the
21 Medical Assistance Program established under Article V of the
22 Illinois Public Aid Code.
23 (b) As an alternative to the benefits set forth in
24 subsection (a), and when cost-effective, the Department may
25 offer families subsidies toward the cost of privately sponsored

health insurance, including employer-sponsored health insurance.

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

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

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

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

1 (Source: P.A. 97-689, eff. 6-14-12.)

2 (215 ILCS 170/40)
3 (Section scheduled to be repealed on October 1, 2019)
4 Sec. 40. Cost-sharing.
5 (a) Children and young adults enrolled in the Program under
6 subsection (a) of Section 35 are subject to the following
7 cost-sharing requirements:
8 (1) The Department, by rule, shall set forth
9 requirements concerning co-payments and coinsurance for
10 health care services and monthly premiums. This
11 cost-sharing shall be on a sliding scale based on family
12 income. The Department may periodically modify such
13 cost-sharing.
14 (2) Notwithstanding paragraph (1), there shall be no
15 co-payment required for well-baby or well-child health
16 care, including, but not limited to, age-appropriate
17 immunizations as required under State or federal law.
18 (b) Children and young adults enrolled in a privately
19 sponsored health insurance plan under subsection (b) of Section
20 35 are subject to the cost-sharing provisions stated in the
21 privately sponsored health insurance plan.
22 (c) Notwithstanding any other provision of law, rates paid
23 by the Department shall not be used in any way to determine the
24 usual and customary or reasonable charge, which is the charge
25 for health care that is consistent with the average rate or

charge for similar services furnished by similar providers in a certain geographic area.

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

(215 ILCS 170/45)

(Section scheduled to be repealed on October 1, 2019)

Sec. 45. Study; contracts.

(a) The Department shall conduct a study that includes, but is not limited to, the following:

(1) Establishing estimates, broken down by regions of the State, of the number of children with and without health insurance coverage; the number of children who are eligible for Medicaid or the Children's Health Insurance Program, and, of that number, the number who are enrolled in Medicaid or the Children's Health Insurance Program; and the number of children with access to dependent coverage through an employer, and, of that number, the number who are enrolled in dependent coverage through an employer.

(2) Surveying those families whose children have access to employer-sponsored dependent coverage but who decline such coverage as to the reasons for declining coverage.

(3) Ascertaining, for the population of children accessing employer-sponsored dependent coverage or who have access to such coverage, the comprehensiveness of dependent coverage available, the amount of cost-sharing

currently paid by the employees, and the cost-sharing associated with such coverage.

(4) Measuring the health outcomes or other benefits for children utilizing the Covering ALL KIDS and Young Adults Health Insurance Program and analyzing the effects on utilization of healthcare services for children after enrollment in the Program compared to the preceding period of uninsured status.

(b) The studies described in subsection (a) shall be conducted in a manner that compares a time period preceding or at the initiation of the program with a later period.

(c) The Department shall submit the preliminary results of the study to the Governor and the General Assembly no later than July 1, 2008 and shall submit the final results to the Governor and the General Assembly no later than July 1, 2010.

(d) The Department shall submit copies of all contracts awarded for the administration of the Program to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.

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

(215 ILCS 170/47)

(Section scheduled to be repealed on October 1, 2019)

Sec. 47. Program information. The Department shall report to the General Assembly no later than September 1 of each year

beginning in 2007, all of the following information:

(a) The number of professionals serving in the primary care case management program, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(b) The number of non-primary care providers accepting referrals, by specialty designation, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(c) The number of individuals enrolled in the Covering ALL KIDS and Young Adults Health Insurance Program by income or premium level and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/56)

(Section scheduled to be repealed on October 1, 2019)

Sec. 56. Care coordination.

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

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

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

1 (c) To qualify for compliance with this Section, the 50%
2 goal shall be achieved by enrolling medical assistance
3 enrollees from each medical assistance enrollment category,
4 including parents, children, seniors, and people with
5 disabilities to the extent that current State Medicaid payment
6 laws would not limit federal matching funds for recipients in
7 care coordination programs. In addition, services must be more
8 comprehensively defined and more risk shall be assumed than in
9 the Department's primary care case management program as of the
10 effective date of this amendatory Act of the 96th General
11 Assembly.
12 (d) The Department shall report to the General Assembly in
13 a separate part of its annual medical assistance program
14 report, beginning April, 2012 until April, 2016, on the
15 progress and implementation of the care coordination program
16 initiatives established by the provisions of this amendatory
17 Act of the 96th General Assembly. The Department shall include
18 in its April 2011 report a full analysis of federal laws or
19 regulations regarding upper payment limitations to providers
20 and the necessary revisions or adjustments in rate
21 methodologies and payments to providers under this Code that
22 would be necessary to implement coordinated care with full
23 financial risk by a party other than the Department.
24 (Source: P.A. 96-1501, eff. 1-25-11.)

25 Section 55. The Illinois Public Aid Code is amended by

1 changing Sections 5-5, 5-29, and 5-30 as follows:

2 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
3 Sec. 5-5. Medical services. The Illinois Department, by
4 rule, shall determine the quantity and quality of and the rate
5 of reimbursement for the medical assistance for which payment
6 will be authorized, and the medical services to be provided,
7 which may include all or part of the following: (1) inpatient
8 hospital services; (2) outpatient hospital services; (3) other
9 laboratory and X-ray services; (4) skilled nursing home
10 services; (5) physicians' services whether furnished in the
11 office, the patient's home, a hospital, a skilled nursing home,
12 or elsewhere; (6) medical care, or any other type of remedial
13 care furnished by licensed practitioners; (7) home health care
14 services; (8) private duty nursing service; (9) clinic
15 services; (10) dental services, including prevention and
16 treatment of periodontal disease and dental caries disease for
17 pregnant women, provided by an individual licensed to practice
18 dentistry or dental surgery; for purposes of this item (10),
19 "dental services" means diagnostic, preventive, or corrective
20 procedures provided by or under the supervision of a dentist in
21 the practice of his or her profession; (11) physical therapy
22 and related services; (12) prescribed drugs, dentures, and
23 prosthetic devices; and eyeglasses prescribed by a physician
24 skilled in the diseases of the eye, or by an optometrist,
25 whichever the person may select; (13) other diagnostic,

1 screening, preventive, and rehabilitative services, including
2 to ensure that the individual's need for intervention or
3 treatment of mental disorders or substance use disorders or
4 co-occurring mental health and substance use disorders is
5 determined using a uniform screening, assessment, and
6 evaluation process inclusive of criteria, for children and
7 adults; for purposes of this item (13), a uniform screening,
8 assessment, and evaluation process refers to a process that
9 includes an appropriate evaluation and, as warranted, a
10 referral; "uniform" does not mean the use of a singular
11 instrument, tool, or process that all must utilize; (14)
12 transportation and such other expenses as may be necessary;
13 (15) medical treatment of sexual assault survivors, as defined
14 in Section 1a of the Sexual Assault Survivors Emergency
15 Treatment Act, for injuries sustained as a result of the sexual
16 assault, including examinations and laboratory tests to
17 discover evidence which may be used in criminal proceedings
18 arising from the sexual assault; (16) the diagnosis and
19 treatment of sickle cell anemia; and (17) any other medical
20 care, and any other type of remedial care recognized under the
21 laws of this State. The term "any other type of remedial care"
22 shall include nursing care and nursing home service for persons
23 who rely on treatment by spiritual means alone through prayer
24 for healing.

25 Notwithstanding any other provision of this Section, a
26 comprehensive tobacco use cessation program that includes

purchasing prescription drugs or prescription medical devices approved by the Food and Drug Administration shall be covered under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

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

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

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under

1 this provision, the vendor or vendors must serve only
2 individuals enrolled in a school within the CPS system. Claims
3 for services provided by CPS's vendor or vendors to recipients
4 of benefits in the medical assistance program under this Code,
5 the Children's Health Insurance Program, or the Covering ALL
6 KIDS and Young Adults Health Insurance Program shall be
7 submitted to the Department or the MCE in which the individual
8 is enrolled for payment and shall be reimbursed at the
9 Department's or the MCE's established rates or rate
10 methodologies for eyeglasses.

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

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

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

22 On and after July 1, 2018, the Department of Healthcare and
23 Family Services shall provide dental services to any adult who
24 is otherwise eligible for assistance under the medical
25 assistance program. As used in this paragraph, "dental
26 services" means diagnostic, preventative, restorative, or

1 corrective procedures, including procedures and services for
2 the prevention and treatment of periodontal disease and dental
3 caries disease, provided by an individual who is licensed to
4 practice dentistry or dental surgery or who is under the
5 supervision of a dentist in the practice of his or her
6 profession.

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

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

The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

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

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

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

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

positive genetic testing, or other risk factors.

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

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

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the

1 Federal Register or publishes a comment in the Federal Register
2 or issues an opinion, guidance, or other action that would
3 require the State, pursuant to any provision of the Patient
4 Protection and Affordable Care Act (Public Law 111-148),
5 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
6 successor provision, to defray the cost of any coverage for
7 breast tomosynthesis outlined in this paragraph, then the
8 requirement that an insurer cover breast tomosynthesis is
9 inoperative other than any such coverage authorized under
10 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
11 the State shall not assume any obligation for the cost of
12 coverage for breast tomosynthesis set forth in this paragraph.
13 On and after January 1, 2016, the Department shall ensure
14 that all networks of care for adult clients of the Department
15 include access to at least one breast imaging Center of Imaging
16 Excellence as certified by the American College of Radiology.
17 On and after January 1, 2012, providers participating in a
18 quality improvement program approved by the Department shall be
19 reimbursed for screening and diagnostic mammography at the same
20 rate as the Medicare program's rates, including the increased
21 reimbursement for digital mammography.
22 The Department shall convene an expert panel including
23 representatives of hospitals, free-standing mammography
24 facilities, and doctors, including radiologists, to establish
25 quality standards for mammography.
26 On and after January 1, 2017, providers participating in a

1 breast cancer treatment quality improvement program approved
2 by the Department shall be reimbursed for breast cancer
3 treatment at a rate that is no lower than 95% of the Medicare
4 program's rates for the data elements included in the breast
5 cancer treatment quality program.

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

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

19 The Department shall establish a methodology to remind
20 women who are age-appropriate for screening mammography, but
21 who have not received a mammogram within the previous 18
22 months, of the importance and benefit of screening mammography.
23 The Department shall work with experts in breast cancer
24 outreach and patient navigation to optimize these reminders and
25 shall establish a methodology for evaluating their
26 effectiveness and modifying the methodology based on the

1 evaluation.
2 The Department shall establish a performance goal for
3 primary care providers with respect to their female patients
4 over age 40 receiving an annual mammogram. This performance
5 goal shall be used to provide additional reimbursement in the
6 form of a quality performance bonus to primary care providers
7 who meet that goal.
8 The Department shall devise a means of case-managing or
9 patient navigation for beneficiaries diagnosed with breast
10 cancer. This program shall initially operate as a pilot program
11 in areas of the State with the highest incidence of mortality
12 related to breast cancer. At least one pilot program site shall
13 be in the metropolitan Chicago area and at least one site shall
14 be outside the metropolitan Chicago area. On or after July 1,
15 2016, the pilot program shall be expanded to include one site
16 in western Illinois, one site in southern Illinois, one site in
17 central Illinois, and 4 sites within metropolitan Chicago. An
18 evaluation of the pilot program shall be carried out measuring
19 health outcomes and cost of care for those served by the pilot
20 program compared to similarly situated patients who are not
21 served by the pilot program.
22 The Department shall require all networks of care to
23 develop a means either internally or by contract with experts
24 in navigation and community outreach to navigate cancer
25 patients to comprehensive care in a timely fashion. The
26 Department shall require all networks of care to include access

1 for patients diagnosed with cancer to at least one academic
2 commission on cancer-accredited cancer program as an
3 in-network covered benefit.

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

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

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

1 health care, and other pertinent programs directed at reducing
2 the number of drug-affected infants born to recipients of
3 medical assistance.
4 Neither the Department of Healthcare and Family Services
5 nor the Department of Human Services shall sanction the
6 recipient solely on the basis of her substance abuse.
7 The Illinois Department shall establish such regulations
8 governing the dispensing of health services under this Article
9 as it shall deem appropriate. The Department should seek the
10 advice of formal professional advisory committees appointed by
11 the Director of the Illinois Department for the purpose of
12 providing regular advice on policy and administrative matters,
13 information dissemination and educational activities for
14 medical and health care providers, and consistency in
15 procedures to the Illinois Department.
16 The Illinois Department may develop and contract with
17 Partnerships of medical providers to arrange medical services
18 for persons eligible under Section 5-2 of this Code.
19 Implementation of this Section may be by demonstration projects
20 in certain geographic areas. The Partnership shall be
21 represented by a sponsor organization. The Department, by rule,
22 shall develop qualifications for sponsors of Partnerships.
23 Nothing in this Section shall be construed to require that the
24 sponsor organization be a medical organization.
25 The sponsor must negotiate formal written contracts with
26 medical providers for physician services, inpatient and

1 outpatient hospital care, home health services, treatment for
2 alcoholism and substance abuse, and other services determined
3 necessary by the Illinois Department by rule for delivery by
4 Partnerships. Physician services must include prenatal and
5 obstetrical care. The Illinois Department shall reimburse
6 medical services delivered by Partnership providers to clients
7 in target areas according to provisions of this Article and the
8 Illinois Health Finance Reform Act, except that:

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

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

17 (3) Persons receiving medical services through
18 Partnerships may receive medical and case management
19 services above the level usually offered through the
20 medical assistance program.

21 Medical providers shall be required to meet certain
22 qualifications to participate in Partnerships to ensure the
23 delivery of high quality medical services. These
24 qualifications shall be determined by rule of the Illinois
25 Department and may be higher than qualifications for
26 participation in the medical assistance program. Partnership

1 sponsors may prescribe reasonable additional qualifications
2 for participation by medical providers, only with the prior
3 written approval of the Illinois Department.

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

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

16 The Illinois Department shall require health care
17 providers to maintain records that document the medical care
18 and services provided to recipients of Medical Assistance under
19 this Article. Such records must be retained for a period of not
20 less than 6 years from the date of service or as provided by
21 applicable State law, whichever period is longer, except that
22 if an audit is initiated within the required retention period
23 then the records must be retained until the audit is completed
24 and every exception is resolved. The Illinois Department shall
25 require health care providers to make available, when
26 authorized by the patient, in writing, the medical records in a

1 timely fashion to other health care providers who are treating
2 or serving persons eligible for Medical Assistance under this
3 Article. All dispensers of medical services shall be required
4 to maintain and retain business and professional records
5 sufficient to fully and accurately document the nature, scope,
6 details and receipt of the health care provided to persons
7 eligible for medical assistance under this Code, in accordance
8 with regulations promulgated by the Illinois Department. The
9 rules and regulations shall require that proof of the receipt
10 of prescription drugs, dentures, prosthetic devices and
11 eyeglasses by eligible persons under this Section accompany
12 each claim for reimbursement submitted by the dispenser of such
13 medical services. No such claims for reimbursement shall be
14 approved for payment by the Illinois Department without such
15 proof of receipt, unless the Illinois Department shall have put
16 into effect and shall be operating a system of post-payment
17 audit and review which shall, on a sampling basis, be deemed
18 adequate by the Illinois Department to assure that such drugs,
19 dentures, prosthetic devices and eyeglasses for which payment
20 is being made are actually being received by eligible
21 recipients. Within 90 days after September 16, 1984 (the
22 effective date of Public Act 83-1439), the Illinois Department
23 shall establish a current list of acquisition costs for all
24 prosthetic devices and any other items recognized as medical
25 equipment and supplies reimbursable under this Article and
26 shall update such list on a quarterly basis, except that the

1 acquisition costs of all prescription drugs shall be updated no
2 less frequently than every 30 days as required by Section
3 5-5.12.
4 Notwithstanding any other law to the contrary, the Illinois
5 Department shall, within 365 days after July 22, 2013 (the
6 effective date of Public Act 98-104), establish procedures to
7 permit skilled care facilities licensed under the Nursing Home
8 Care Act to submit monthly billing claims for reimbursement
9 purposes. Following development of these procedures, the
10 Department shall, by July 1, 2016, test the viability of the
11 new system and implement any necessary operational or
12 structural changes to its information technology platforms in
13 order to allow for the direct acceptance and payment of nursing
14 home claims.
15 Notwithstanding any other law to the contrary, the Illinois
16 Department shall, within 365 days after August 15, 2014 (the
17 effective date of Public Act 98-963), establish procedures to
18 permit ID/DD facilities licensed under the ID/DD Community Care
19 Act and MC/DD facilities licensed under the MC/DD Act to submit
20 monthly billing claims for reimbursement purposes. Following
21 development of these procedures, the Department shall have an
22 additional 365 days to test the viability of the new system and
23 to ensure that any necessary operational or structural changes
24 to its information technology platforms are implemented.
25 The Illinois Department shall require all dispensers of
26 medical services, other than an individual practitioner or

1 group of practitioners, desiring to participate in the Medical
2 Assistance program established under this Article to disclose
3 all financial, beneficial, ownership, equity, surety or other
4 interests in any and all firms, corporations, partnerships,
5 associations, business enterprises, joint ventures, agencies,
6 institutions or other legal entities providing any form of
7 health care services in this State under this Article.

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

16 Enrollment of a vendor shall be subject to a provisional
17 period and shall be conditional for one year. During the period
18 of conditional enrollment, the Department may terminate the
19 vendor's eligibility to participate in, or may disenroll the
20 vendor from, the medical assistance program without cause.
21 Unless otherwise specified, such termination of eligibility or
22 disenrollment is not subject to the Department's hearing
23 process. However, a disenrolled vendor may reapply without
24 penalty.

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

1 the vendor.

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

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

24 To be eligible for payment consideration, a vendor's
25 payment claim or bill, either as an initial claim or as a
26 resubmitted claim following prior rejection, must be received

1 by the Illinois Department, or its fiscal intermediary, no
2 later than 180 days after the latest date on the claim on which
3 medical goods or services were provided, with the following
4 exceptions:

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

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

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

17 (4) In the case of a provider operated by a unit of
18 local government with a population exceeding 3,000,000
19 when local government funds finance federal participation
20 for claims payments.

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

1 adjudication by the primary payer.
2 In the case of long term care facilities, within 45
3 calendar days of receipt by the facility of required
4 prescreening information, new admissions with associated
5 admission documents shall be submitted through the Medical
6 Electronic Data Interchange (MEDI) or the Recipient
7 Eligibility Verification (REV) System or shall be submitted
8 directly to the Department of Human Services using required
9 admission forms. Effective September 1, 2014, admission
10 documents, including all prescreening information, must be
11 submitted through MEDI or REV. Confirmation numbers assigned to
12 an accepted transaction shall be retained by a facility to
13 verify timely submittal. Once an admission transaction has been
14 completed, all resubmitted claims following prior rejection
15 are subject to receipt no later than 180 days after the
16 admission transaction has been completed.
17 Claims that are not submitted and received in compliance
18 with the foregoing requirements shall not be eligible for
19 payment under the medical assistance program, and the State
20 shall have no liability for payment of those claims.
21 To the extent consistent with applicable information and
22 privacy, security, and disclosure laws, State and federal
23 agencies and departments shall provide the Illinois Department
24 access to confidential and other information and data necessary
25 to perform eligibility and payment verifications and other
26 Illinois Department functions. This includes, but is not

1 limited to: information pertaining to licensure;
2 certification; earnings; immigration status; citizenship; wage
3 reporting; unearned and earned income; pension income;
4 employment; supplemental security income; social security
5 numbers; National Provider Identifier (NPI) numbers; the
6 National Practitioner Data Bank (NPDB); program and agency
7 exclusions; taxpayer identification numbers; tax delinquency;
8 corporate information; and death records.

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

25 Beginning in fiscal year 2013, the Illinois Department
26 shall set forth a request for information to identify the

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

13 The Illinois Department shall establish policies,
14 procedures, standards and criteria by rule for the acquisition,
15 repair and replacement of orthotic and prosthetic devices and
16 durable medical equipment. Such rules shall provide, but not be
17 limited to, the following services: (1) immediate repair or
18 replacement of such devices by recipients; and (2) rental,
19 lease, purchase or lease-purchase of durable medical equipment
20 in a cost-effective manner, taking into consideration the
21 recipient's medical prognosis, the extent of the recipient's
22 needs, and the requirements and costs for maintaining such
23 equipment. Subject to prior approval, such rules shall enable a
24 recipient to temporarily acquire and use alternative or
25 substitute devices or equipment pending repairs or
26 replacements of any device or equipment previously authorized

1 for such recipient by the Department. Notwithstanding any
2 provision of Section 5-5f to the contrary, the Department may,
3 by rule, exempt certain replacement wheelchair parts from prior
4 approval and, for wheelchairs, wheelchair parts, wheelchair
5 accessories, and related seating and positioning items,
6 determine the wholesale price by methods other than actual
7 acquisition costs.

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

16 In order to promote environmental responsibility, meet the
17 needs of recipients and enrollees, and achieve significant cost
18 savings, the Department, or a managed care organization under
19 contract with the Department, may provide recipients or managed
20 care enrollees who have a prescription or Certificate of
21 Medical Necessity access to refurbished durable medical
22 equipment under this Section (excluding prosthetic and
23 orthotic devices as defined in the Orthotics, Prosthetics, and
24 Pedorthics Practice Act and complex rehabilitation technology
25 products and associated services) through the State's
26 assistive technology program's reutilization program, using

1 staff with the Assistive Technology Professional (ATP)
2 Certification if the refurbished durable medical equipment:
3 (i) is available; (ii) is less expensive, including shipping
4 costs, than new durable medical equipment of the same type;
5 (iii) is able to withstand at least 3 years of use; (iv) is
6 cleaned, disinfected, sterilized, and safe in accordance with
7 federal Food and Drug Administration regulations and guidance
8 governing the reprocessing of medical devices in health care
9 settings; and (v) equally meets the needs of the recipient or
10 enrollee. The reutilization program shall confirm that the
11 recipient or enrollee is not already in receipt of same or
12 similar equipment from another service provider, and that the
13 refurbished durable medical equipment equally meets the needs
14 of the recipient or enrollee. Nothing in this paragraph shall
15 be construed to limit recipient or enrollee choice to obtain
16 new durable medical equipment or place any additional prior
17 authorization conditions on enrollees of managed care
18 organizations.

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

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

23 The Illinois Department shall develop and operate, in
24 cooperation with other State Departments and agencies and in
25 compliance with applicable federal laws and regulations,
26 appropriate and effective systems of health care evaluation and

1 programs for monitoring of utilization of health care services
2 and facilities, as it affects persons eligible for medical
3 assistance under this Code.

4 The Illinois Department shall report annually to the
5 General Assembly, no later than the second Friday in April of
6 1979 and each year thereafter, in regard to:

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

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

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

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

15 The period covered by each report shall be the 3 years
16 ending on the June 30 prior to the report. The report shall
17 include suggested legislation for consideration by the General
18 Assembly. The requirement for reporting to the General Assembly
19 shall be satisfied by filing copies of the report as required
20 by Section 3.1 of the General Assembly Organization Act, and
21 filing such additional copies with the State Government Report
22 Distribution Center for the General Assembly as is required
23 under paragraph (t) of Section 7 of the State Library Act.

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

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

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

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

25 Notwithstanding any other provision of this Code to the
26 contrary, on or after July 1, 2015, all FDA approved forms of

1 medication assisted treatment prescribed for the treatment of
2 alcohol dependence or treatment of opioid dependence shall be
3 covered under both fee for service and managed care medical
4 assistance programs for persons who are otherwise eligible for
5 medical assistance under this Article and shall not be subject
6 to any (1) utilization control, other than those established
7 under the American Society of Addiction Medicine patient
8 placement criteria, (2) prior authorization mandate, or (3)
9 lifetime restriction limit mandate.

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

22 Upon federal approval, the Department shall provide
23 coverage and reimbursement for all drugs that are approved for
24 marketing by the federal Food and Drug Administration and that
25 are recommended by the federal Public Health Service or the
26 United States Centers for Disease Control and Prevention for

1 pre-exposure prophylaxis and related pre-exposure prophylaxis
2 services, including, but not limited to, HIV and sexually
3 transmitted infection screening, treatment for sexually
4 transmitted infections, medical monitoring, assorted labs, and
5 counseling to reduce the likelihood of HIV infection among
6 individuals who are not infected with HIV but who are at high
7 risk of HIV infection.

8 A federally qualified health center, as defined in Section
9 1905(l)(2)(B) of the federal Social Security Act, shall be
10 reimbursed by the Department in accordance with the federally
11 qualified health center's encounter rate for services provided
12 to medical assistance recipients that are performed by a dental
13 hygienist, as defined under the Illinois Dental Practice Act,
14 working under the general supervision of a dentist and employed
15 by a federally qualified health center.

16 Notwithstanding any other provision of this Code, the
17 Illinois Department shall authorize licensed dietitian
18 nutritionists and certified diabetes educators to counsel
19 senior diabetes patients in the senior diabetes patients' homes
20 to remove the hurdle of transportation for senior diabetes
21 patients to receive treatment.

22 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
23 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
24 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
25 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
26 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,

1 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
2 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.
3 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;
4 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.
5 12-10-18.)

6 (305 ILCS 5/5-29)
7 Sec. 5-29. Income Limits and Parental Responsibility. In
8 light of the unprecedented fiscal crisis confronting the State,
9 it is the intent of the General Assembly to explore whether the
10 income limits and income counting methods established for
11 children under the Covering ALL KIDS and Young Adults Health
12 Insurance Act, pursuant to this amendatory Act of the 96th
13 General Assembly, should apply to medical assistance programs
14 available to children made eligible under the Illinois Public
15 Aid Code, including through home and community based services
16 waiver programs authorized under Section 1915(c) of the Social
17 Security Act, where parental income is currently not considered
18 in determining a child's eligibility for medical assistance.
19 The Department of Healthcare and Family Services is hereby
20 directed, with the participation of the Department of Human
21 Services and stakeholders, to conduct an analysis of these
22 programs to determine parental cost sharing opportunities, how
23 these opportunities may impact the children currently in the
24 programs, waivers and on the waiting list, and any other
25 factors which may increase efficiencies and decrease State

costs. The Department is further directed to review how services under these programs and waivers may be provided by the use of a combination of skilled, unskilled, and uncompensated care and to advise as to what revisions to the Nurse Practice Act, and Acts regulating other relevant professions, are necessary to accomplish this combination of care. The Department shall submit a written analysis on the children's programs and waivers as part of the Department's annual Medicaid reports due to the General Assembly in 2011 and 2012.

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

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

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

from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

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

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with

1 disabilities to the extent that current State Medicaid payment
2 laws would not limit federal matching funds for recipients in
3 care coordination programs. In addition, services must be more
4 comprehensively defined and more risk shall be assumed than in
5 the Department's primary care case management program as of
6 January 25, 2011 (the effective date of Public Act 96-1501).

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

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

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

1 (2) The Department may utilize and expand upon existing
2 contractual arrangements with integrated care plans under
3 the Integrated Care Program for providing the coordinated
4 care provisions of this Section.
5 (3) Payment for such coordinated care shall be based on
6 arrangements where the State pays for performance related
7 to mental health outcomes on a capitated basis in which a
8 fixed monthly premium per recipient is paid and full
9 financial risk is assumed for the delivery of services, or
10 through other risk-based payment arrangements such as
11 provider-based care coordination.
12 (4) The Department shall examine whether chronic
13 mental health management programs and services for
14 recipients with specific chronic mental health conditions
15 do any or all of the following:
16 (A) Improve the patient's overall mental health in
17 a more expeditious and cost-effective manner.
18 (B) Lower costs in other aspects of the medical
19 assistance program, such as hospital admissions,
20 emergency room visits, or more frequent and
21 inappropriate psychotropic drug use.
22 (5) The Department shall work with the facilities and
23 any integrated care plan participating in the program to
24 identify and correct barriers to the successful
25 implementation of this subsection (e) prior to and during
26 the implementation to best facilitate the goals and

1 objectives of this subsection (e).

2 (f) A hospital that is located in a county of the State in
3 which the Department mandates some or all of the beneficiaries
4 of the Medical Assistance Program residing in the county to
5 enroll in a Care Coordination Program, as set forth in Section
6 5-30 of this Code, shall not be eligible for any non-claims
7 based payments not mandated by Article V-A of this Code for
8 which it would otherwise be qualified to receive, unless the
9 hospital is a Coordinated Care Participating Hospital no later
10 than 60 days after June 14, 2012 (the effective date of Public
11 Act 97-689) or 60 days after the first mandatory enrollment of
12 a beneficiary in a Coordinated Care program. For purposes of
13 this subsection, "Coordinated Care Participating Hospital"
14 means a hospital that meets one of the following criteria:

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

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

capitated rates.

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

(g) No later than August 1, 2013, the Department shall issue a purchase of care solicitation for Accountable Care Entities (ACE) to serve any children and parents or caretaker relatives of children eligible for medical assistance under this Article. An ACE may be a single corporate structure or a network of providers organized through contractual relationships with a single corporate entity. The solicitation shall require that:

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

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

1 hospitals, and behavioral healthcare.
2 (3) An ACE shall have a governance structure that
3 includes the major components of the health care delivery
4 system, including one representative from each of the
5 groups listed in paragraph (2).
6 (4) An ACE must be an integrated delivery system,
7 including a network able to provide the full range of
8 services needed by Medicaid beneficiaries and system
9 capacity to securely pass clinical information across
10 participating entities and to aggregate and analyze that
11 data in order to coordinate care.
12 (5) An ACE must be capable of providing both care
13 coordination and complex case management, as necessary, to
14 beneficiaries. To be responsive to the solicitation, a
15 potential ACE must outline its care coordination and
16 complex case management model and plan to reduce the cost
17 of care.
18 (6) In the first 18 months of operation, unless the ACE
19 selects a shorter period, an ACE shall be paid care
20 coordination fees on a per member per month basis that are
21 projected to be cost neutral to the State during the term
22 of their payment and, subject to federal approval, be
23 eligible to share in additional savings generated by their
24 care coordination.
25 (7) In months 19 through 36 of operation, unless the
26 ACE selects a shorter period, an ACE shall be paid on a

1 pre-paid capitation basis for all medical assistance
2 covered services, under contract terms similar to Managed
3 Care Organizations (MCO), with the Department sharing the
4 risk through either stop-loss insurance for extremely high
5 cost individuals or corridors of shared risk based on the
6 overall cost of the total enrollment in the ACE. The ACE
7 shall be responsible for claims processing, encounter data
8 submission, utilization control, and quality assurance.

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

14 The Department shall allow potential ACE entities 5 months
15 from the date of the posting of the solicitation to submit
16 proposals. After the solicitation is released, in addition to
17 the MCO rate development data available on the Department's
18 website, subject to federal and State confidentiality and
19 privacy laws and regulations, the Department shall provide 2
20 years of de-identified summary service data on the targeted
21 population, split between children and adults, showing the
22 historical type and volume of services received and the cost of
23 those services to those potential bidders that sign a data use
24 agreement. The Department may add up to 2 non-state government
25 employees with expertise in creating integrated delivery
26 systems to its review team for the purchase of care

1 solicitation described in this subsection. Any such
2 individuals must sign a no-conflict disclosure and
3 confidentiality agreement and agree to act in accordance with
4 all applicable State laws.

5 During the first 2 years of an ACE's operation, the
6 Department shall provide claims data to the ACE on its
7 enrollees on a periodic basis no less frequently than monthly.

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

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

18 (h) Department contracts with MCOs and other entities
19 reimbursed by risk based capitation shall have a minimum
20 medical loss ratio of 85%, shall require the entity to
21 establish an appeals and grievances process for consumers and
22 providers, and shall require the entity to provide a quality
23 assurance and utilization review program. Entities contracted
24 with the Department to coordinate healthcare regardless of risk
25 shall be measured utilizing the same quality metrics. The
26 quality metrics may be population specific. Any contracted

1 entity serving at least 5,000 seniors or people with
2 disabilities or 15,000 individuals in other populations
3 covered by the Medical Assistance Program that has been
4 receiving full-risk capitation for a year shall be accredited
5 by a national accreditation organization authorized by the
6 Department within 2 years after the date it is eligible to
7 become accredited. The requirements of this subsection shall
8 apply to contracts with MCOs entered into or renewed or
9 extended after June 1, 2013.

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

20 (i) Unless otherwise required by federal law, Medicaid
21 Managed Care Entities and their respective business associates
22 shall not disclose, directly or indirectly, including by
23 sending a bill or explanation of benefits, information
24 concerning the sensitive health services received by enrollees
25 of the Medicaid Managed Care Entity to any person other than
26 covered entities and business associates, which may receive,

1 use, and further disclose such information solely for the
2 purposes permitted under applicable federal and State laws and
3 regulations if such use and further disclosure satisfies all
4 applicable requirements of such laws and regulations. The
5 Medicaid Managed Care Entity or its respective business
6 associates may disclose information concerning the sensitive
7 health services if the enrollee who received the sensitive
8 health services requests the information from the Medicaid
9 Managed Care Entity or its respective business associates and
10 authorized the sending of a bill or explanation of benefits.
11 Communications including, but not limited to, statements of
12 care received or appointment reminders either directly or
13 indirectly to the enrollee from the health care provider,
14 health care professional, and care coordinators, remain
15 permissible. Medicaid Managed Care Entities or their
16 respective business associates may communicate directly with
17 their enrollees regarding care coordination activities for
18 those enrollees.

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

23 For purposes of this subsection, the term "sensitive health
24 services" means mental health services, substance abuse
25 treatment services, reproductive health services, family
26 planning services, services for sexually transmitted

1 infections and sexually transmitted diseases, and services for
2 sexual assault or domestic abuse. Services include prevention,
3 screening, consultation, examination, treatment, or follow-up.
4 For purposes of this subsection, "business associate",
5 "covered entity", "disclosure", and "use" have the meanings
6 ascribed to those terms in 45 CFR 160.103.
7 Nothing in this subsection shall be construed to relieve a
8 Medicaid Managed Care Entity or the Department of any duty to
9 report incidents of sexually transmitted infections to the
10 Department of Public Health or to the local board of health in
11 accordance with regulations adopted under a statute or
12 ordinance or to report incidents of sexually transmitted
13 infections as necessary to comply with the requirements under
14 Section 5 of the Abused and Neglected Child Reporting Act or as
15 otherwise required by State or federal law.
16 The Department shall create policy in order to implement
17 the requirements in this subsection.
18 (j) Managed Care Entities (MCEs), including MCOs and all
19 other care coordination organizations, shall develop and
20 maintain a written language access policy that sets forth the
21 standards, guidelines, and operational plan to ensure language
22 appropriate services and that is consistent with the standard
23 of meaningful access for populations with limited English
24 proficiency. The language access policy shall describe how the
25 MCEs will provide all of the following required services:
26 (1) Translation (the written replacement of text from

1 one language into another) of all vital documents and forms
2 as identified by the Department.
3 (2) Qualified interpreter services (the oral
4 communication of a message from one language into another
5 by a qualified interpreter).
6 (3) Staff training on the language access policy,
7 including how to identify language needs, access and
8 provide language assistance services, work with
9 interpreters, request translations, and track the use of
10 language assistance services.
11 (4) Data tracking that identifies the language need.
12 (5) Notification to participants on the availability
13 of language access services and on how to access such
14 services.
15 (k) The Department shall actively monitor the contractual
16 relationship between Managed Care Organizations (MCOs) and any
17 dental administrator contracted by an MCO to provide dental
18 services. The Department shall adopt appropriate dental
19 Healthcare Effectiveness Data and Information Set (HEDIS)
20 measures and shall include the Annual Dental Visit (ADV) HEDIS
21 measure in its Health Plan Comparison Tool and Illinois
22 Medicaid Plan Report Card that is available on the Department's
23 website for enrolled individuals.
24 The Department shall collect from each MCO specific
25 information about the types of contracted, broad-based care
26 coordination occurring between the MCO and any dental

1 administrator, including, but not limited to, pregnant women
2 and diabetic patients in need of oral care.
3 (Source: P.A. 99-106, eff. 1-1-16; 99-181, eff. 7-29-15;
4 99-566, eff. 1-1-17; 99-642, eff. 7-28-16; 100-587, eff.
5 6-4-18.)

6 Section 60. The Prenatal and Newborn Care Act is amended by
7 changing Section 9 as follows:

8 (410 ILCS 225/9)
9 Sec. 9. The Illinois Department of Healthcare and Family
10 Services; consultation; data reporting.
11 (a) The Illinois Department of Healthcare and Family
12 Services, which administers the Illinois Medicaid Program and
13 the Covering ALL KIDS and Young Adults Health Insurance
14 Program, shall consult with statewide organizations focused on
15 premature infant healthcare in order to:
16 (1) examine and improve hospital discharge and
17 follow-up care procedures for premature infants born
18 earlier than 37 weeks gestational age to ensure
19 standardized and coordinated processes are followed as
20 premature infants leave the hospital from either a Level 1
21 (well baby nursery), Level 2 (step down or transitional
22 nursery), or Level 3 (neonatal intensive care unit) unit
23 and transition to follow-up care by a health care provider
24 in the community; and

1 (2) use guidance from the Centers for Medicare and
2 Medicaid Services' Neonatal Outcome Improvement Project to
3 implement programs to improve newborn outcome, reduce
4 newborn health costs, and establish ongoing quality
5 improvement for newborns.
6 (b) In consultation with statewide organizations
7 representing hospitals, the Department of Public Health shall
8 consider mechanisms to collect discharge data for purposes of
9 analyzing readmission rates of certain premature infants.
10 (Source: P.A. 96-1117, eff. 7-20-10.)

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Statutes amended in order of appearance

20 ILCS 1705/71a
30 ILCS 105/6z-52
30 ILCS 105/6z-73
30 ILCS 105/6z-81
30 ILCS 105/25 from Ch. 127, par. 161
30 ILCS 540/3-2
35 ILCS 105/3-8
35 ILCS 120/2-9
35 ILCS 200/15-86
40 ILCS 5/24-102 from Ch. 108 1/2, par. 24-102
110 ILCS 948/10
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215 ILCS 106/23
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215 ILCS 170/45

1 215 ILCS 170/47
2 215 ILCS 170/56
3 305 ILCS 5/5-5 from Ch. 23, par. 5-5
4 305 ILCS 5/5-29
5 305 ILCS 5/5-30
6 410 ILCS 225/9