Sen. Heather Steans

Filed: 1/5/2011

AMENDMENT TO HOUSE BILL 5420

AMENDMENT NO. _____. Amend House Bill 5420, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The State Budget Law of the Civil Administrative Code of Illinois is amended by adding Section 50-30 as follows:

(15 ILCS 20/50-30 new)

Sec. 50-30. Long-term care rebalancing. In light of the increasing demands confronting the State in meeting the needs of individuals utilizing long-term care services under the medical assistance program and any other long-term care related benefit program administered by the State, it is the intent of the General Assembly to address the needs of both the State and the individuals eligible for such services by cost effective and efficient means through the advancement of a long-term care

rebalancing initiative. Notwithstanding any State law to the contrary, and subject to federal laws, regulations, and court decrees, the following shall apply to the long-term care rebalancing initiative:

(1) "Long-term care rebalancing", as used in this Section, means removing barriers to community living for people of all ages with disabilities and long-term illnesses by offering individuals utilizing long-term care services a reasonable array of options, in particular adequate choices of community and institutional options, to achieve a balance between the proportion of total Medicaid long-term support expenditures used for institutional services and those used for community-based supports.

(2) Subject to the provisions of this Section, the Governor shall create a unified budget report identifying the budgets of all State agencies offering long-term care services to persons in either institutional or community settings, including the budgets of State-operated facilities for persons with developmental disabilities that shall include, but not be limited to, the following service and financial data:

(A) A breakdown of long-term care services, defined as institutional or community care, by the State agency primarily responsible for administration of the program.

(B) Actual and estimated enrollment, caseload, service hours, or service days provided for long-term care services described in a consistent format for those services, for each of the following age groups: older adults 65 years of age and older, younger adults 21 years of age through 64 years of age, and children under 21 years of age.

(C) Funding sources for long-term care services.

(D) Comparison of service and expenditure data, by services, both in aggregate and per person enrolled.

(3) For each fiscal year, the unified budget report described in subdivision (2) shall be prepared with reference to the prioritized outcomes for that fiscal year contemplated by Sections 50-5 and 50-25 of this Code.

(4) Each State agency responsible for the administration of long-term care services shall provide an analysis of the progress being made by the agency to transition persons from institutional to community settings, where appropriate, as part of the State's long-term care rebalancing initiative.

(5) The Governor may designate amounts set aside for institutional services appropriated from the General Revenue Fund or any other State fund that receives monies for long-term care services to be transferred to all State agencies responsible for the administration of community-based long-term care programs, including, but

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

(6) This Section shall be liberally construed and interpreted in a manner that allows the State to advance its long-term care rebalancing initiatives.

Section 10. The State Finance Act is amended by changing

Sections 13.2 and 25 as follows:

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

Sec. 13.2. Transfers among line item appropriations.

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

(a-1) No transfers may be made from one agency to another agency, nor may transfers be made from one institution of higher education to another institution of higher education except as provided by subsection (a-4).

(a-2) Except as otherwise provided in this Section, transfers may be made only among the objects of expenditure enumerated in this Section, except that no funds may be transferred from any appropriation for personal services, from any appropriation for State contributions to the State Employees' Retirement System, from any separate appropriation for employee retirement contributions paid by the employer, nor from any appropriation for State contribution for employee group insurance. During State fiscal year 2005, an agency may transfer amounts among its appropriations within the same treasury fund for personal services, employee retirement contributions paid by employer, and State Contributions to

retirement systems; notwithstanding and in addition to the transfers authorized in subsection (c) of this Section, the fiscal year 2005 transfers authorized in this sentence may be made in an amount not to exceed 2% of the aggregate amount appropriated to an agency within the same treasury fund. During State fiscal year 2007, the Departments of Children and Family Services, Corrections, Human Services, and Juvenile Justice may transfer amounts among their respective appropriations within the same treasury fund for personal services, employee retirement contributions paid by employer, and State contributions to retirement systems. During State fiscal year 2010, the Department of Transportation may transfer amounts among their respective appropriations within the same treasury fund for personal services, employee retirement contributions paid by employer, and State contributions to retirement systems. During State fiscal year 2010 only, an agency may transfer amounts among its respective appropriations within the same treasury fund for personal services, employee retirement contributions paid by employer, and State contributions to retirement systems. Notwithstanding, and in addition to, the transfers authorized in subsection (c) of this Section, these transfers may be made in an amount not to exceed 2% of the aggregate amount appropriated to an agency within the same treasury fund.

(a-3) Further, if an agency receives a separate appropriation for employee retirement contributions paid by

the employer, any transfer by that agency into an appropriation for personal services must be accompanied by a corresponding transfer into the appropriation for employee retirement contributions paid by the employer, in an amount sufficient to meet the employer share of the employee contributions required to be remitted to the retirement system.

(a-4) Long-Term Care Rebalancing. The Governor may designate amounts set aside for institutional services appropriated from the General Revenue Fund or any other State fund that receives monies for long-term care services to be transferred to all State agencies responsible for the administration of community-based long-term care programs, including, but not limited to, community-based long-term care programs administered by the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging, provided that the Director of Healthcare and Family Services first certifies that the amounts being transferred are necessary for the purpose of assisting persons in or at risk of being in institutional care to transition to community-based settings, including the financial data needed to prove the need for the transfer of funds. The total amounts transferred shall not exceed 4% in total of the amounts appropriated from the General Revenue Fund or any other State fund that receives monies for long-term care services for each fiscal year. A notice of the fund transfer must be made to the General Assembly and posted at a minimum on the Department of

Healthcare and Family Services website, the Governor's Office of Management and Budget website, and any other website the Governor sees fit. These postings shall serve as notice to the General Assembly of the amounts to be transferred. Notice shall be given at least 30 days prior to transfer.

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

The Department of Healthcare and Family Services is authorized to make transfers representing savings attributable to not increasing grants due to the births of additional children from line items for payments of cash grants to line items for payments for employment and social services for the purposes outlined in subsection (f) of Section 4-2 of the Illinois Public Aid Code.

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

The Department on Aging is authorized to make transfers not exceeding 2% of the aggregate amount appropriated to it within the same treasury fund for the following Community Care Program line items among these same line items: Homemaker and Senior

Companion Services, Alternative Senior Services, Case Coordination Units, and Adult Day Care Services.

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

The State Board of Education is authorized to make transfers from line item appropriations within the same treasury fund for General State Aid and General State Aid - Hold Harmless, provided that no such transfer may be made unless the amount transferred is no longer required for the purpose for which that appropriation was made, to the line item appropriation for Transitional Assistance when the balance remaining in such line item appropriation is insufficient for the purpose for which the appropriation was made.

The State Board of Education is authorized to make transfers between the following line item appropriations within the same treasury fund: Disabled Student Services/Materials (Section 14-13.01 of the School Code), Disabled Student Transportation Reimbursement (Section 14-13.01 of the School Code), Disabled Student Tuition - Private Tuition (Section 14-7.02 of the School Code),

Extraordinary Special Education (Section 14-7.02b of the School Code), Reimbursement for Free Lunch/Breakfast Program, Summer School Payments (Section 18-4.3 of the School Code), and Transportation - Regular/Vocational Reimbursement (Section 29-5 of the School Code). Such transfers shall be made only when the balance remaining in one or more such line item appropriations is insufficient for the purpose for which the appropriation was made and provided that no such transfer may be made unless the amount transferred is no longer required for the purpose for which that appropriation was made.

During State fiscal years 2010 and 2011 only, the Department of Healthcare and Family Services is authorized to make transfers not exceeding 4% of the aggregate amount appropriated to it, within the same treasury fund, among the various line items appropriated for Medical Assistance.

(c) The sum of such transfers for an agency in a fiscal year shall not exceed 2% of the aggregate amount appropriated to it within the same treasury fund for the following objects: Personal Services; Extra Help; Student and Inmate Compensation; State Contributions to Retirement Systems; State Contributions to Social Security; State Contribution for Employee Group Insurance; Contractual Services; Travel; Commodities; Printing; Equipment; Electronic Data Processing; Operation of Automotive Equipment; Telecommunications Services; Travel and Allowance for Committed, Paroled and Discharged Prisoners; Library Books; Federal Matching Grants

for Student Loans; Refunds; Workers' Compensation, Occupational Disease, and Tort Claims; and, in appropriations to institutions of higher education, Awards and Grants. Notwithstanding the above, any amounts appropriated for payment of workers' compensation claims to an agency to which the authority to evaluate, administer and pay such claims has been delegated by the Department of Central Management Services may be transferred to any other expenditure object where such amounts exceed the amount necessary for the payment of such claims.

(c-1) Special provisions for State fiscal year 2003. Notwithstanding any other provision of this Section to the contrary, for State fiscal year 2003 only, transfers among line item appropriations to an agency from the same treasury fund may be made provided that the sum of such transfers for an agency in State fiscal year 2003 shall not exceed 3% of the aggregate amount appropriated to that State agency for State fiscal year 2003 for the following objects: personal services, except that no transfer may be approved which reduces the aggregate appropriations for personal services within an agency; extra help; student and inmate compensation; State contributions to retirement systems; State contributions to social security; State contributions for employee group insurance; contractual services; travel; commodities; printing; equipment; electronic data processing; operation of automotive equipment; telecommunications services; travel and

allowance for committed, paroled, and discharged prisoners; library books; federal matching grants for student loans; refunds; workers' compensation, occupational disease, and tort claims; and, in appropriations to institutions of higher education, awards and grants.

(c-2) Special provisions for State fiscal year 2005. Notwithstanding subsections (a), (a-2), and (c), for State fiscal year 2005 only, transfers may be made among any line item appropriations from the same or any other treasury fund for any objects or purposes, without limitation, when the balance remaining in one or more such line item appropriations is insufficient for the purpose for which the appropriation was made, provided that the sum of those transfers by a State agency shall not exceed 4% of the aggregate amount appropriated to that State agency for fiscal year 2005.

(d) Transfers among appropriations made to agencies of the Legislative and Judicial departments and to the constitutionally elected officers in the Executive branch require the approval of the officer authorized in Section 10 of this Act to approve and certify vouchers. Transfers among appropriations made to the University of Illinois, Southern Illinois University, Chicago State University, Eastern Illinois University, Governors State University, Illinois State University, Northeastern Illinois University, Northern Illinois University, Western Illinois University, the Illinois Mathematics and Science Academy and the Board of Higher

Education require the approval of the Board of Higher Education and the Governor. Transfers among appropriations to all other agencies require the approval of the Governor.

The officer responsible for approval shall certify that the transfer is necessary to carry out the programs and purposes for which the appropriations were made by the General Assembly and shall transmit to the State Comptroller a certified copy of the approval which shall set forth the specific amounts transferred so that the Comptroller may change his records accordingly. The Comptroller shall furnish the Governor with information copies of all transfers approved for agencies of the Legislative and Judicial departments and transfers approved by the constitutionally elected officials of the Executive branch other than the Governor, showing the amounts transferred and indicating the dates such changes were entered on the Comptroller's records.

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

(1) Disabled Student Personnel Reimbursement (Section

14-13.01 of the School Code);

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

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

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

(5) Reimbursement for Free Lunch/Breakfast Programs;

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

(7) Transportation - Regular/Vocational Reimbursement (Section 29-5 of the School Code);

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

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

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

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

Sec. 25. Fiscal year limitations.

(a) All appropriations shall be available for expenditure for the fiscal year or for a lesser period if the Act making that appropriation so specifies. A deficiency or emergency appropriation shall be available for expenditure only through

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

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

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

business on October 31.

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

(b-4) Medical payments may be made by the Department of Healthcare and Family Services and medical payments and child care payments may be made by the Department of Human Services (as successor to the Department of Public Aid) from appropriations for those purposes for any fiscal year, without regard to the fact that the medical or child care services

being compensated for by such payment may have been rendered in a prior fiscal year; and payments may be made at the direction of the Department of Healthcare and Family Services ~~Central Management Services~~ from the Health Insurance Reserve Fund and the Local Government Health Insurance Reserve Fund without regard to any fiscal year limitations, except as required by subsection (j) of this Section. Beginning on June 30, 2021, medical payments made by the Department of Healthcare and Family Services, child care payments made by the Department of Human Services, and payments made at the discretion of the Department of Healthcare and Family Services from the Health Insurance Reserve Fund and the Local Government Health Insurance Reserve Fund payable from appropriations that have otherwise expired may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

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

Department of Human Services relating to substance abuse treatment services payable from appropriations that have otherwise expired may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

(b-6) Additionally, payments may be made by the Department of Human Services from its appropriations, or any other State agency from its appropriations with the approval of the Department of Human Services, from the Immigration Reform and Control Fund for purposes authorized pursuant to the Immigration Reform and Control Act of 1986, without regard to any fiscal year limitations, except as required by subsection (j) of this Section. Beginning on June 30, 2021, payments made by the Department of Human Services from the Immigration Reform and Control Fund for purposes authorized pursuant to the Immigration Reform and Control Act of 1986 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.

~~Further, with respect to costs incurred in fiscal years 2002 and 2003 only, payments may be made by the State Treasurer from its appropriations from the Capital Litigation Trust Fund without regard to any fiscal year limitations.~~

~~Lease payments may be made by the Department of Central Management Services under the sale and leaseback provisions of Section 7.4 of the State Property Control Act with respect to~~

~~the James R. Thompson Center and the Elgin Mental Health Center and surrounding land from appropriations for that purpose without regard to any fiscal year limitations.~~

~~Lease payments may be made under the sale and leaseback provisions of Section 7.5 of the State Property Control Act with respect to the Illinois State Toll Highway Authority headquarters building and surrounding land without regard to any fiscal year limitations.~~

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

(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), and the Department of Healthcare and Family Services from their respective appropriations for grants for medical care to or on behalf of persons suffering from chronic renal disease, persons suffering from hemophilia, rape victims, and 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, the Department of Human Services, and the Department of Healthcare and Family Services from their respective appropriations for grants for medical care to or on behalf of persons suffering from chronic renal disease, persons suffering from hemophilia, rape victims, and premature and high-mortality risk infants and their mothers and for grants for supplemental food supplies provided under the United States Department of Agriculture Women, Infants and Children Nutrition Program payable from appropriations that have otherwise expired may be paid out of the expiring appropriations during the 4-month period ending at the close of business on October 31.

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

(e) The Department of Healthcare and Family Services, the Department of Human Services (acting as successor to the Department of Public Aid), and the Department of Human Services making fee-for-service payments relating to substance abuse treatment services provided during a previous fiscal year shall each annually submit to the State Comptroller, Senate President, Senate Minority Leader, Speaker of the House, House Minority Leader, the respective Chairmen and Minority Spokesmen of the Appropriations Committees of the Senate and the House, on or before November 30, a report that shall document by program or service category those expenditures from the most recently completed fiscal year used to pay for (i) services provided in prior fiscal years and (ii) services for which claims were received in prior fiscal years.

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

(g) In addition, each annual report required to be

submitted by the Department of Healthcare and Family Services under subsection (e) shall include the following information with respect to the State's Medicaid program:

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

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

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

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

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

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

(2) issuing credits, refunding through inter-fund transfers, or reducing future inter-fund transfers during

the subsequent fiscal year for all user agency payments or authorized inter-fund transfers received during the prior fiscal year which were in excess of the final amounts owed by the user agency for that period; and

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

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

(i-1) Beginning on July 1, 2021, all outstanding liabilities, not payable during the 4-month lapse period as described in subsections (b-1), (b-3), (b-4), (b-5), (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.

(Source: P.A. 95-331, eff. 8-21-07; 96-928, eff. 6-15-10; 96-958, eff. 7-1-10; revised 7-22-10.)

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

(30 ILCS 540/3-2)

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

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

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

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

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

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

(3) The provisions of this amendatory Act of the 96th General Assembly reducing the interest rate on pharmacy claims under Article V of the Illinois Public Aid Code to

1.0% per month shall apply to any pharmacy bills for services and goods under Article V of the Illinois Public Aid Code received on or after the date 60 days before the effective date of this amendatory Act of the 96th General Assembly.

(Source: P.A. 96-555, eff. 8-18-09; 96-802, eff. 1-1-10; 96-959, eff. 7-1-10; 96-1000, eff. 7-2-10.)

Section 20. The Illinois Income Tax Act is amended by changing Section 917 as follows:

(35 ILCS 5/917) (from Ch. 120, par. 9-917)

Sec. 917. Confidentiality and information sharing.

(a) Confidentiality. Except as provided in this Section, all information received by the Department from returns filed under this Act, or from any investigation conducted under the provisions of this Act, shall be confidential, except for official purposes within the Department or pursuant to official procedures for collection of any State tax or pursuant to an investigation or audit by the Illinois State Scholarship Commission of a delinquent student loan or monetary award or enforcement of any civil or criminal penalty or sanction imposed by this Act or by another statute imposing a State tax, and any person who divulges any such information in any manner, except for such purposes and pursuant to order of the Director or in accordance with a proper judicial order, shall be guilty

of a Class A misdemeanor. However, the provisions of this paragraph are not applicable to information furnished to (i) the Department of Healthcare and Family Services (formerly Department of Public Aid), State's Attorneys, and the Attorney General for child support enforcement purposes and (ii) a licensed attorney representing the taxpayer where an appeal or a protest has been filed on behalf of the taxpayer. If it is necessary to file information obtained pursuant to this Act in a child support enforcement proceeding, the information shall be filed under seal.

(b) Public information. Nothing contained in this Act shall prevent the Director from publishing or making available to the public the names and addresses of persons filing returns under this Act, or from publishing or making available reasonable statistics concerning the operation of the tax wherein the contents of returns are grouped into aggregates in such a way that the information contained in any individual return shall not be disclosed.

(c) Governmental agencies. The Director may make available to the Secretary of the Treasury of the United States or his delegate, or the proper officer or his delegate of any other state imposing a tax upon or measured by income, for exclusively official purposes, information received by the Department in the administration of this Act, but such permission shall be granted only if the United States or such other state, as the case may be, grants the Department

substantially similar privileges. The Director may exchange information with the Department of Healthcare and Family Services and the Department of Human Services (acting as successor to the Department of Public Aid under the Department of Human Services Act) for the purpose of verifying sources and amounts of income and for other purposes directly connected with the administration of this Act, the Illinois Public Aid Code, and any other health benefit program administered by the State ~~and the Illinois Public Aid Code~~. The Director may exchange information with the Director of the Department of Employment Security for the purpose of verifying sources and amounts of income and for other purposes directly connected with the administration of this Act and Acts administered by the Department of Employment Security. The Director may make available to the Illinois Workers' Compensation Commission information regarding employers for the purpose of verifying the insurance coverage required under the Workers' Compensation Act and Workers' Occupational Diseases Act. The Director may exchange information with the Illinois Department on Aging for the purpose of verifying sources and amounts of income for purposes directly related to confirming eligibility for participation in the programs of benefits authorized by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.

The Director may make available to any State agency, including the Illinois Supreme Court, which licenses persons to

engage in any occupation, information that a person licensed by such agency has failed to file returns under this Act or pay the tax, penalty and interest shown therein, or has failed to pay any final assessment of tax, penalty or interest due under this Act. The Director may make available to any State agency, including the Illinois Supreme Court, information regarding whether a bidder, contractor, or an affiliate of a bidder or contractor has failed to file returns under this Act or pay the tax, penalty, and interest shown therein, or has failed to pay any final assessment of tax, penalty, or interest due under this Act, for the limited purpose of enforcing bidder and contractor certifications. For purposes of this Section, the term "affiliate" means any entity that (1) directly, indirectly, or constructively controls another entity, (2) is directly, indirectly, or constructively controlled by another entity, or (3) is subject to the control of a common entity. For purposes of this subsection (a), an entity controls another entity if it owns, directly or individually, more than 10% of the voting securities of that entity. As used in this subsection (a), the term "voting security" means a security that (1) confers upon the holder the right to vote for the election of members of the board of directors or similar governing body of the business or (2) is convertible into, or entitles the holder to receive upon its exercise, a security that confers such a right to vote. A general partnership interest is a voting security.

The Director may make available to any State agency, including the Illinois Supreme Court, units of local government, and school districts, information regarding whether a bidder or contractor is an affiliate of a person who is not collecting and remitting Illinois Use taxes, for the limited purpose of enforcing bidder and contractor certifications.

The Director may also make available to the Secretary of State information that a corporation which has been issued a certificate of incorporation by the Secretary of State has failed to file returns under this Act or pay the tax, penalty and interest shown therein, or has failed to pay any final assessment of tax, penalty or interest due under this Act. An assessment is final when all proceedings in court for review of such assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted. For taxable years ending on or after December 31, 1987, the Director may make available to the Director or principal officer of any Department of the State of Illinois, information that a person employed by such Department has failed to file returns under this Act or pay the tax, penalty and interest shown therein. For purposes of this paragraph, the word "Department" shall have the same meaning as provided in Section 3 of the State Employees Group Insurance Act of 1971.

(d) The Director shall make available for public inspection in the Department's principal office and for publication, at

cost, administrative decisions issued on or after January 1, 1995. These decisions are to be made available in a manner so that the following taxpayer information is not disclosed:

(1) The names, addresses, and identification numbers of the taxpayer, related entities, and employees.

(2) At the sole discretion of the Director, trade secrets or other confidential information identified as such by the taxpayer, no later than 30 days after receipt of an administrative decision, by such means as the Department shall provide by rule.

The Director shall determine the appropriate extent of the deletions allowed in paragraph (2). In the event the taxpayer does not submit deletions, the Director shall make only the deletions specified in paragraph (1).

The Director shall make available for public inspection and publication an administrative decision within 180 days after the issuance of the administrative decision. The term "administrative decision" has the same meaning as defined in Section 3-101 of Article III of the Code of Civil Procedure. Costs collected under this Section shall be paid into the Tax Compliance and Administration Fund.

(e) Nothing contained in this Act shall prevent the Director from divulging information to any person pursuant to a request or authorization made by the taxpayer, by an authorized representative of the taxpayer, or, in the case of information related to a joint return, by the spouse filing the joint

return with the taxpayer.

(Source: P.A. 94-1074, eff. 12-26-06; 95-331, eff. 8-21-07.)

Section 25. The Illinois Insurance Code is amended by changing Section 5.5 as follows:

(215 ILCS 5/5.5)

Sec. 5.5. Compliance with the Department of Healthcare and Family Services. A company authorized to do business in this State or accredited by the State to issue policies of health insurance, including but not limited to, self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service as a condition of doing business in the State must:

(1) provide to the Department of Healthcare and Family Services, or any successor agency, on at least a quarterly basis if so requested by the Department, information ~~upon request information~~ to determine during what period any individual may be, or may have been, covered by a health insurer and the nature of the coverage that is or was provided by the health insurer, including the name, address, and identifying number of the plan;

(2) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the medical programs of the Department of Healthcare and Family Services, or any successor agency, under this Code or the Illinois Public Aid Code;

(3) respond to any inquiry by the Department of Healthcare and Family Services regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(4) agree not to deny a claim submitted by the Department of Healthcare and Family Services solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim if (i) the claim is submitted by the Department of Healthcare and Family Services within the 3-year period beginning on the date on which the item or service was furnished and (ii) any action by the Department of Healthcare and Family Services to enforce its rights with respect to such claim is commenced within 6 years of its submission of such claim.

In cases in which the Department of Healthcare and Family Services has determined that an entity that provides health

insurance coverage has established a pattern of failure to provide the information required under this Section, and has subsequently certified that determination, along with supporting documentation, to the Director of the Department of Insurance, the Director of the Department of Insurance, based upon the certification of determination made by the Department of Healthcare and Family Services, may commence regulatory proceedings in accordance with all applicable provisions of the Illinois Insurance Code.

(Source: P.A. 95-632, eff. 9-25-07.)

Section 30. The Children's Health Insurance Program Act is amended by changing Section 15 and by adding Sections 7, 21, 23, and 26 as follows:

(215 ILCS 106/7 new)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to the recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall

be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory

Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(215 ILCS 106/15)

Sec. 15. Operation of the Program. There is hereby created a Children's Health Insurance Program. The Program shall operate subject to appropriation and shall be administered by the Department of Healthcare and Family Services. The Department shall have the powers and authority granted to the Department under the Illinois Public Aid Code, including, but not limited to, Section 11-5.1 of the Code. The Department may contract with a Third Party Administrator or other entities to administer and oversee any portion of this Program.

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

(215 ILCS 106/21 new)

Sec. 21. Presumptive eligibility. Beginning on the effective date of this amendatory Act of the 96th General Assembly and except where federal law requires presumptive eligibility, no adult may be presumed eligible for health care coverage under the Program, and the Department may not cover any service rendered to an adult unless the adult has completed an application for benefits, all required verifications have been received and the Department or its designee has found the

adult eligible for the date on which that service was provided. Nothing in this Section shall apply to pregnant women.

(215 ILCS 106/23 new)

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 Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs

of enrollees with developmental, mental health, physical, and age-related disabilities.

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

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the

progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

(215 ILCS 106/26 new)

Sec. 26. Moratorium on eligibility expansions. Beginning on the effective date of this amendatory Act of the 96th General Assembly, there shall be a 2-year moratorium on the expansion of eligibility through increasing financial eligibility standards, or through increasing income disregards, or through the creation of new programs that would add new categories of eligible individuals under the medical assistance program under the Illinois Public Aid Code in addition to those categories covered on January 1, 2011. This moratorium shall not apply to expansions required as a federal condition of State participation in the medical assistance program.

Section 35. The Covering ALL KIDS Health Insurance Act is amended by changing Sections 15, 20, and 98 and by adding

Sections 7, 21, 26, 36, and 56 as follows:

(215 ILCS 170/7 new)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at

their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services,

the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(215 ILCS 170/15)

(Section scheduled to be repealed on July 1, 2011)

Sec. 15. Operation of Program. The Covering ALL KIDS Health Insurance Program is created. The Program shall be administered by the Department of Healthcare and Family Services. The Department shall have the same powers and authority to administer the Program as are provided to the Department in connection with the Department's administration of the

Illinois Public Aid Code, including, but not limited to, the provisions under Section 11-5.1 of the Code, and the Children's Health Insurance Program Act. The Department shall coordinate the Program with the existing children's health programs operated by the Department and other State agencies.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/20)
(Section scheduled to be repealed on July 1, 2011)
Sec. 20. Eligibility.
(a) To be eligible for the Program, a person must be a child:
(1) who is a resident of the State of Illinois; ~~and~~
(2) who is ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act; ~~and~~
(3) either (i) who has been without health insurance coverage for ~~a period set forth by the Department in rules, but not less than 6 months during the first month of operation of the Program, 7 months during the second month of operation, 8 months during the third month of operation, 9 months during the fourth month of operation, 10 months during the fifth month of operation, 11 months during the sixth month of operation, and~~ 12 months ~~thereafter~~, (ii) whose parent has lost employment that made available affordable dependent health insurance coverage, until such

time as affordable employer-sponsored dependent health insurance coverage is again available for the child as set forth by the Department in rules, (iii) who is a newborn whose responsible relative does not have available affordable private or employer-sponsored health insurance, or (iv) who, within one year of applying for coverage under this Act, lost medical benefits under the Illinois Public Aid Code or the Children's Health Insurance Program Act; and ~~.~~

(3.5) whose household income, as determined by the Department, is at or below 300% of the federal poverty level. This item (3.5) is effective July 1, 2011.

An entity that provides health insurance coverage (as defined in Section 2 of the Comprehensive Health Insurance Plan Act) to Illinois residents shall provide health insurance data match to the Department of Healthcare and Family Services as provided by and subject to Section 5.5 of the Illinois Insurance Code ~~for the purpose of determining eligibility for the Program under this Act~~.

The Department of Healthcare and Family Services, in collaboration with the Department ~~of Financial and Professional Regulation, Division~~ of Insurance, shall adopt rules governing the exchange of information under this Section. The rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records, including provisions under the Federal Health

Insurance Portability and Accountability Act (HIPAA).

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

(c) The Department, at its discretion, may take into account the affordability of dependent health insurance when determining whether employer-sponsored dependent health insurance coverage is available upon reemployment of a child's parent as provided in subdivision (a)(3).

(d) A child who is determined to be eligible for the Program shall remain eligible for 12 months, provided that the child maintains his or her residence in this State, has not yet attained 19 years of age, and is not excluded under subsection (e).

(e) A child is not eligible for coverage under the Program if:

(1) the premium required under Section 40 has not been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid; re-enrollment shall be completed before the next covered medical visit, and the first

month's required premium shall be paid in advance of the next covered medical visit; or

(2) the child is an inmate of a public institution or an institution for mental diseases.

(f) The Department may ~~shall~~ adopt ~~eligibility~~ rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program in conformance with Section 7 of this Act; ~~rules regarding annual renewals of eligibility for the Program;~~ rules providing for re-enrollment, grace periods, notice 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. 96-1272, eff. 1-1-11.)

(215 ILCS 170/21 new)

Sec. 21. Presumptive eligibility. Beginning on the effective date of this amendatory Act of the 96th General Assembly and except where federal law or regulation requires presumptive eligibility, no adult may be presumed eligible for health care coverage under the Program and the Department may not cover any service rendered to an adult unless the adult has completed an application for benefits, all required verifications have been received, and the Department or its designee has found the adult eligible for the date on which that service was provided. Nothing in this Section shall apply to pregnant women.

(215 ILCS 170/36 new)

Sec. 36. Moratorium on eligibility expansions. Beginning on the effective date of this amendatory Act of the 96th General Assembly, there shall be a 2-year moratorium on the expansion of eligibility through increasing financial eligibility standards, or through increasing income disregards, or through the creation of new programs that would add new categories of eligible individuals under the medical assistance program under the Illinois Public Aid Code in addition to those categories covered on January 1, 2011. This

moratorium shall not apply to expansions required as a federal condition of State participation in the medical assistance program.

(215 ILCS 170/56 new)

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 Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii)

to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

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

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program

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

(215 ILCS 170/98)

(Section scheduled to be repealed on July 1, 2011)

Sec. 98. Repealer. This Act is repealed on July 1, 2016 ~~July 1, 2011~~.

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

Section 40. The Illinois Public Aid Code is amended by changing Sections 5-4.1, 5-5.12, 5-11, 8A-2.5, and 11-26 and by adding Sections 5-1.3, 5-1.4, 5-2.03, 5-11a, 5-29, 5-30, and 11-5.1 as follows:

(305 ILCS 5/5-1.3 new)

Sec. 5-1.3. Payer of last resort. To the extent permissible under federal law, the State may pay for medical services only after payment from all other sources of payment have been

exhausted, or after the Department has determined that pursuit of such payment is economically unfeasible. Applicants for, and recipients of, medical assistance under this Code shall disclose to the State all insurance coverage they have. To the extent permissible under federal law, the State shall require vendors of medical services to bill third-party payers for services that may be covered by those third-party payers prior to submission of a request for payment to the State. The Department shall, to the extent permissible under federal law, reject a request for payment of a medical service that should first have been submitted to a third-party payer.

(305 ILCS 5/5-1.4 new)

Sec. 5-1.4. Moratorium on eligibility expansions. Beginning on the effective date of this amendatory Act of the 96th General Assembly, there shall be a 2-year moratorium on the expansion of eligibility through increasing financial eligibility standards, or through increasing income disregards, or through the creation of new programs which would add new categories of eligible individuals under the medical assistance program in addition to those categories covered on January 1, 2011. This moratorium shall not apply to expansions required as a federal condition of State participation in the medical assistance program.

(305 ILCS 5/5-2.03 new)

Sec. 5-2.03. Presumptive eligibility. Beginning on the effective date of this amendatory Act of the 96th General Assembly and except where federal law requires presumptive eligibility, no adult may be presumed eligible for medical assistance under this Code and the Department may not cover any service rendered to an adult unless the adult has completed an application for benefits, all required verifications have been received, and the Department or its designee has found the adult eligible for the date on which that service was provided. Nothing in this Section shall apply to pregnant women.

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

Sec. 5-4.1. Co-payments. The Department may by rule provide that recipients under any Article of this Code shall pay a fee as a co-payment for services. Co-payments shall be maximized to the extent permitted by federal law ~~may not exceed $3 for brand name drugs, $1 for other pharmacy services other than for generic drugs, and $2 for physicians services, dental services, optical services and supplies, chiropractic services, podiatry services, and encounter rate clinic services. There shall be no co-payment for generic drugs. Co-payments may not exceed $3 for hospital outpatient and clinic services~~. Provided, however, that any such rule must provide that no co-payment requirement can exist for renal dialysis, radiation therapy, cancer chemotherapy, or insulin, and other products necessary on a recurring basis, the absence of which would be life

threatening, or where co-payment expenditures for required services and/or medications for chronic diseases that the Illinois Department shall by rule designate shall cause an extensive financial burden on the recipient, and provided no co-payment shall exist for emergency room encounters which are for medical emergencies. The Department shall seek approval of a State plan amendment that allows pharmacies to refuse to dispense drugs in circumstances where the recipient does not pay the required co-payment. In the event the State plan amendment is rejected, co-payments may not exceed $3 for brand name drugs, $1 for other pharmacy services other than for generic drugs, and $2 for physician services, dental services, optical services and supplies, chiropractic services, podiatry services, and encounter rate clinic services. There shall be no co-payment for generic drugs. Co-payments may not exceed $3 for hospital outpatient and clinic services.

(Source: P.A. 92-597, eff. 6-28-02; 93-593, eff. 8-25-03.)

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

Sec. 5-5.12. Pharmacy payments.

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

(b) Pharmacies providing prescription drugs under this

Article shall be reimbursed at a rate which shall include a professional dispensing fee as determined by the Illinois Department, plus the current acquisition cost of the prescription drug dispensed. The Illinois Department shall update its information on the acquisition costs of all prescription drugs no less frequently than every 30 days. However, the Illinois Department may set the rate of reimbursement for the acquisition cost, by rule, at a percentage of the current average wholesale acquisition cost.

(c) (Blank).

(d) The Department shall not impose requirements for prior approval based on a preferred drug list for anti-retroviral, anti-hemophilic factor concentrates, or any atypical antipsychotics, conventional antipsychotics, or anticonvulsants used for the treatment of serious mental illnesses until 30 days after it has conducted a study of the impact of such requirements on patient care and submitted a report to the Speaker of the House of Representatives and the President of the Senate. The Department shall review utilization of narcotic medications in the medical assistance program and impose utilization controls that protect against abuse.

(e) When making determinations as to which drugs shall be on a prior approval list, the Department shall include as part of the analysis for this determination, the degree to which a drug may affect individuals in different ways based on factors

including the gender of the person taking the medication.

(f) ~~(e)~~ The Department shall cooperate with the Department of Public Health and the Department of Human Services Division of Mental Health in identifying psychotropic medications that, when given in a particular form, manner, duration, or frequency (including "as needed") in a dosage, or in conjunction with other psychotropic medications to a nursing home resident, may constitute a chemical restraint or an "unnecessary drug" as defined by the Nursing Home Care Act or Titles XVIII and XIX of the Social Security Act and the implementing rules and regulations. The Department shall require prior approval for any such medication prescribed for a nursing home resident that appears to be a chemical restraint or an unnecessary drug. The Department shall consult with the Department of Human Services Division of Mental Health in developing a protocol and criteria for deciding whether to grant such prior approval.

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

(Source: P.A. 96-1269, eff. 7-26-10; 96-1372, eff. 7-29-10; revised 9-2-10.)

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

Sec. 5-11. Co-operative arrangements; contracts with other State agencies, health care and rehabilitation organizations,

and fiscal intermediaries.

(a) The Illinois Department may enter into co-operative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services to the end that there may be maximum utilization of such services in the provision of medical assistance.

The Illinois Department shall, not later than June 30, 1993, enter into one or more co-operative arrangements with the Department of Mental Health and Developmental Disabilities providing that the Department of Mental Health and Developmental Disabilities will be responsible for administering or supervising all programs for services to persons in community care facilities for persons with developmental disabilities, including but not limited to intermediate care facilities, that are supported by State funds or by funding under Title XIX of the federal Social Security Act. The responsibilities of the Department of Mental Health and Developmental Disabilities under these agreements are transferred to the Department of Human Services as provided in the Department of Human Services Act.

The Department may also contract with such State health and rehabilitation agencies and other public or private health care and rehabilitation organizations to act for it in supplying designated medical services to persons eligible therefor under this Article. Any contracts with health services or health

maintenance organizations shall be restricted to organizations which have been certified as being in compliance with standards promulgated pursuant to the laws of this State governing the establishment and operation of health services or health maintenance organizations. The Department shall renegotiate the contracts with health maintenance organizations and managed care community networks that took effect August 1, 2003, so as to produce $70,000,000 savings to the Department net of resulting increases to the fee-for-service program for State fiscal year 2006. The Department may also contract with insurance companies or other corporate entities serving as fiscal intermediaries in this State for the Federal Government in respect to Medicare payments under Title XVIII of the Federal Social Security Act to act for the Department in paying medical care suppliers. The provisions of Section 9 of "An Act in relation to State finance", approved June 10, 1919, as amended, notwithstanding, such contracts with State agencies, other health care and rehabilitation organizations, or fiscal intermediaries may provide for advance payments.

(b) For purposes of this subsection (b), "managed care community network" means an entity, other than a health maintenance organization, that is owned, operated, or governed by providers of health care services within this State and that provides or arranges primary, secondary, and tertiary managed health care services under contract with the Illinois Department exclusively to persons participating in programs

administered by the Illinois Department.

The Illinois Department may certify managed care community networks, including managed care community networks owned, operated, managed, or governed by State-funded medical schools, as risk-bearing entities eligible to contract with the Illinois Department as Medicaid managed care organizations. The Illinois Department may contract with those managed care community networks to furnish health care services to or arrange those services for individuals participating in programs administered by the Illinois Department. The rates for those provider-sponsored organizations may be determined on a prepaid, capitated basis. A managed care community network may choose to contract with the Illinois Department to provide only pediatric health care services. The Illinois Department shall by rule adopt the criteria, standards, and procedures by which a managed care community network may be permitted to contract with the Illinois Department and shall consult with the Department of Insurance in adopting these rules.

A county provider as defined in Section 15-1 of this Code may contract with the Illinois Department to provide primary, secondary, or tertiary managed health care services as a managed care community network without the need to establish a separate entity and shall be deemed a managed care community network for purposes of this Code only to the extent it provides services to participating individuals. A county provider is entitled to contract with the Illinois Department

with respect to any contracting region located in whole or in part within the county. A county provider is not required to accept enrollees who do not reside within the county.

In order to (i) accelerate and facilitate the development of integrated health care in contracting areas outside counties with populations in excess of 3,000,000 and counties adjacent to those counties and (ii) maintain and sustain the high quality of education and residency programs coordinated and associated with local area hospitals, the Illinois Department may develop and implement a demonstration program from managed care community networks owned, operated, managed, or governed by State-funded medical schools. The Illinois Department shall prescribe by rule the criteria, standards, and procedures for effecting this demonstration program.

A managed care community network that contracts with the Illinois Department to furnish health care services to or arrange those services for enrollees participating in programs administered by the Illinois Department shall do all of the following:

(1) Provide that any provider affiliated with the managed care community network may also provide services on a fee-for-service basis to Illinois Department clients not enrolled in such managed care entities.

(2) Provide client education services as determined and approved by the Illinois Department, including but not limited to (i) education regarding appropriate utilization

of health care services in a managed care system, (ii) written disclosure of treatment policies and restrictions or limitations on health services, including, but not limited to, physical services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, and radiological examinations, and (iii) written notice that the enrollee may receive from another provider those covered services that are not provided by the managed care community network.

(3) Provide that enrollees within the system may choose the site for provision of services and the panel of health care providers.

(4) Not discriminate in enrollment or disenrollment practices among recipients of medical services or enrollees based on health status.

(5) Provide a quality assurance and utilization review program that meets the requirements established by the Illinois Department in rules that incorporate those standards set forth in the Health Maintenance Organization Act.

(6) Issue a managed care community network identification card to each enrollee upon enrollment. The card must contain all of the following:

(A) The enrollee's health plan.

(B) The name and telephone number of the enrollee's primary care physician or the site for receiving

primary care services.

(C) A telephone number to be used to confirm eligibility for benefits and authorization for services that is available 24 hours per day, 7 days per week.

(7) Ensure that every primary care physician and pharmacy in the managed care community network meets the standards established by the Illinois Department for accessibility and quality of care. The Illinois Department shall arrange for and oversee an evaluation of the standards established under this paragraph (7) and may recommend any necessary changes to these standards.

(8) Provide a procedure for handling complaints that meets the requirements established by the Illinois Department in rules that incorporate those standards set forth in the Health Maintenance Organization Act.

(9) Maintain, retain, and make available to the Illinois Department records, data, and information, in a uniform manner determined by the Illinois Department, sufficient for the Illinois Department to monitor utilization, accessibility, and quality of care.

(10) (Blank) ~~Provide that the pharmacy formulary used by the managed care community network and its contract providers be no more restrictive than the Illinois Department's pharmaceutical program on the effective date of this amendatory Act of 1998 and as amended after that~~

~~date~~.

The Illinois Department shall contract with an entity or entities to provide external peer-based quality assurance review for the managed health care programs administered by the Illinois Department. The entity shall meet all federal requirements for an external quality review organization ~~be representative of Illinois physicians licensed to practice medicine in all its branches and have statewide geographic representation in all specialities of medical care that are provided in managed health care programs administered by the Illinois Department. The entity may not be a third party payer and shall maintain offices in locations around the State in order to provide service and continuing medical education to physician participants within those managed health care programs administered by the Illinois Department. The review process shall be developed and conducted by Illinois physicians licensed to practice medicine in all its branches. In consultation with the entity, the Illinois Department may contract with other entities for professional peer based quality assurance review of individual categories of services other than services provided, supervised, or coordinated by physicians licensed to practice medicine in all its branches. The Illinois Department shall establish, by rule, criteria to avoid conflicts of interest in the conduct of quality assurance activities consistent with professional peer review standards. All quality assurance activities shall be coordinated by the~~

~~Illinois Department~~.

Each managed care community network must demonstrate its ability to bear the financial risk of serving individuals under this program. The Illinois Department shall by rule adopt standards for assessing the solvency and financial soundness of each managed care community network. Any solvency and financial standards adopted for managed care community networks shall be no more restrictive than the solvency and financial standards adopted under Section 1856(a) of the Social Security Act for provider-sponsored organizations under Part C of Title XVIII of the Social Security Act.

The Illinois Department may implement the amendatory changes to this Code made by this amendatory Act of 1998 through the use of emergency rules in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the adoption of rules to implement these changes is deemed an emergency and necessary for the public interest, safety, and welfare.

(c) Not later than June 30, 1996, the Illinois Department shall enter into one or more cooperative arrangements with the Department of Public Health for the purpose of developing a single survey for nursing facilities, including but not limited to facilities funded under Title XVIII or Title XIX of the federal Social Security Act or both, which shall be administered and conducted solely by the Department of Public Health. The Departments shall test the single survey process on

a pilot basis, with both the Departments of Public Aid and Public Health represented on the consolidated survey team. The pilot will sunset June 30, 1997. After June 30, 1997, unless otherwise determined by the Governor, a single survey shall be implemented by the Department of Public Health which would not preclude staff from the Department of Healthcare and Family Services (formerly Department of Public Aid) from going on-site to nursing facilities to perform necessary audits and reviews which shall not replicate the single State agency survey required by this Act. This Section shall not apply to community or intermediate care facilities for persons with developmental disabilities.

(d) Nothing in this Code in any way limits or otherwise impairs the authority or power of the Illinois Department to enter into a negotiated contract pursuant to this Section with a managed care community network or a health maintenance organization, as defined in the Health Maintenance Organization Act, that provides for termination or nonrenewal of the contract without cause, upon notice as provided in the contract, and without a hearing.

(Source: P.A. 94-48, eff. 7-1-05; 95-331, eff. 8-21-07.)

(305 ILCS 5/5-11a new)

Sec. 5-11a. Health Benefit Information Systems.

(a) It is the intent of the General Assembly to support unified electronic systems initiatives that will improve

management of information related to medical assistance programs. This will include improved management capabilities and new systems for Eligibility, Verification, and Enrollment (EVE) that will simplify and increase efficiencies in and access to the medical assistance programs and ensure program integrity. The Department of Healthcare and Family Services, in coordination with the Department of Human Services and other appropriate state agencies, shall develop a plan by July 1, 2011, that will:

(1) Subject to federal and State privacy and confidentiality laws and regulations, meet standards for timely eligibility verification and enrollment, and annual redetermination of eligibility, of applicants for and recipients of means-tested health benefits sponsored by the State, including medical assistance under this Code.

(2) Receive and update data electronically from the Social Security Administration, the U.S. Postal Service, the Illinois Secretary of State, the Department of Revenue, the Department of Employment Security, and other governmental entities, as appropriate and to the extent allowed by law, for verification of any factor of eligibility for medical assistance and for updating addresses of applicants and recipients of medical assistance and other health benefit programs administered by the Department. Data relevant to eligibility shall be provided for no other purpose than to verify the

eligibility of new applicants or current recipients of health benefits provided by the State. Data shall be requested or provided for any individual only insofar as that new applicant or current recipient's circumstances are relevant to that individual's or another individual's eligibility for State-sponsored health benefits.

(3) Meet federal requirements for timely installation by January 1, 2014 to provide integration with a Health Benefits Exchange pursuant to the requirements of the federal Affordable Care Act and the Reconciliation Act and any subsequent amendments thereto and to ensure capture of the maximum available federal financial participation (FFP).

(4) Meet federal requirements for compliance with architectural standards, including, but not limited to, (i) the use of a module development as outlined by the Medicaid Information Technology Architecture standards, (ii) the use of federally approved open-interfaces where they exist, (iii) the use or the creation of open-interfaces where necessary, and (iv) the use of rules technology that can dynamically accept and modify rules in standard formats.

(5) Include plans to ensure coordination with the State of Illinois Framework Project that will (i) expedite and simplify access to services provided by Illinois human services programs; (ii) streamline administration and data

sharing; (iii) enhance planning capacity, program evaluation, and fraud detection or prevention with access to cross-agency data; and (iv) simplify service reporting for contracted providers.

(b) The Department of Healthcare and Family Services shall continue to plan for and implement a new Medicaid Management Information System (MMIS) and upgrade the capabilities of the MMIS data warehouse. Upgrades shall include, among other things, enhanced capabilities in data analysis including the ability to identify risk factors that could impact the treatment and resulting quality of care, and tools that perform predictive analytics on data applying to newborns, women with high risk pregnancies, and other populations served by the Department.

(c) The Department of Healthcare and Family Services shall report in its annual Medical Assistance program report each April through April, 2015 on the progress and implementation of this plan.

(305 ILCS 5/5-29 new)

Sec. 5-29. Income Limits and Parental Responsibility. In light of the unprecedented fiscal crisis confronting the State, it is the intent of the General Assembly to explore whether the income limits and income counting methods established for children under the Covering ALL KIDS Health Insurance Act, pursuant to this amendatory Act of the 96th General Assembly,

should apply to medical assistance programs available to children made eligible under the Illinois Public Aid Code, including through home and community based services waiver programs authorized under Section 1915(c) of the Social Security Act, where parental income is currently not considered in determining a child's eligibility for medical assistance. The Department of Healthcare and Family Services is hereby directed, with the participation of the Department of Human Services and stakeholders, to conduct an analysis of these programs to determine parental cost sharing opportunities, how these opportunities may impact the children currently in the programs, waivers and on the waiting list, and any other 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.

(305 ILCS 5/5-30 new)

Sec. 5-30. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the

use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers

and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

(305 ILCS 5/8A-2.5)

Sec. 8A-2.5. Unauthorized use of medical assistance.

(a) Any person who knowingly uses, acquires, possesses, or transfers a medical card in any manner not authorized by law or by rules and regulations of the Illinois Department, or who knowingly alters a medical card, or who knowingly uses, acquires, possesses, or transfers an altered medical card, is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.

(b) Any person who knowingly obtains unauthorized medical benefits with or without use of a medical card is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.

(c) The Department may seek to recover any and all State and federal monies for which it has improperly and erroneously paid benefits as a result of a fraudulent action and any civil penalties authorized in this Section. Pursuant to Section 11-14.5 of this Code, the Department may determine the monetary value of benefits improperly and erroneously received. The Department may recover the monies paid for such benefits and interest on that amount at the rate of 5% per annum for the

period from which payment was made to the date upon which repayment is made to the State. Prior to the recovery of any amount paid for benefits allegedly obtained by fraudulent means, the recipient of such benefits shall be afforded an opportunity for a hearing after reasonable notice. The notice shall be served personally or by certified or registered mail or as otherwise provided by law upon the parties or their agents appointed to receive service of process and shall include the following:

(1) A statement of the time, place and nature of the hearing.

(2) A statement of the legal authority and jurisdiction under which the hearing is to be held.

(3) A reference to the particular Sections of the substantive and procedural statutes and rules involved.

(4) Except where a more detailed statement is otherwise provided for by law, a short and plain statement of the matters asserted, the consequences of a failure to respond, and the official file or other reference number.

(5) A statement of the monetary value of the benefits fraudulently received by the person accused.

(6) A statement that, in addition to any other penalties provided by law, a civil penalty in an amount not to exceed $2,000 may be imposed for each fraudulent claim for benefits or payments.

(7) A statement providing that the determination of the

monetary value may be contested by petitioning the Department for an administrative hearing within 30 days from the date of mailing the notice.

(8) The names and mailing addresses of the administrative law judge, all parties, and all other persons to whom the agency gives notice of the hearing unless otherwise confidential by law.

An opportunity shall be afforded all parties to be represented by legal counsel and to respond and present evidence and argument.

Unless precluded by law, disposition may be made of any contested case by stipulation, agreed settlement, consent order, or default.

Any final order, decision, or other determination made, issued or executed by the Director under the provisions of this Article whereby any person is aggrieved shall be subject to review in accordance with the provisions of the Administrative Review Law, and the rules adopted pursuant thereto, which shall apply to and govern all proceeding for the judicial review of final administrative decisions of the Director.

Upon entry of a final administrative decision for repayment of any benefits obtained by fraudulent means, or for any civil penalties assessed, a lien shall attach to all property and assets of such person, firm, corporation, association, agency, institution, or other legal entity until the judgment is satisfied.

Within 12 months of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services will report to the General Assembly on the number of fraud cases identified and pursued, and the fines assessed and collected. The report will also include the Department's analysis as to the use of private sector resources to bring action, investigate, and collect monies owed.

(Source: P.A. 89-289, eff. 1-1-96.)

(305 ILCS 5/11-5.1 new)

Sec. 11-5.1. Eligibility verification. Notwithstanding any other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and

expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior

to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(305 ILCS 5/11-26) (from Ch. 23, par. 11-26)

Sec. 11-26. Recipient's abuse of medical care; restrictions on access to medical care.

(a) When the Department determines, on the basis of statistical norms and medical judgment, that a medical care recipient has received medical services in excess of need and with such frequency or in such a manner as to constitute an abuse of the recipient's medical care privileges, the recipient's access to medical care may be restricted.

(b) When the Department has determined that a recipient is abusing his or her medical care privileges as described in this Section, it may require that the recipient designate a primary provider type ~~primary care provider, primary care pharmacy, or health maintenance organization~~ of the recipient's own choosing to assume responsibility for the recipient's care. For the purposes of this subsection, "primary provider type" means a primary care provider, primary care pharmacy, primary dentist, primary podiatrist, or primary durable medical equipment provider. Instead of requiring a recipient to make a designation as provided in this subsection, the Department, pursuant to rules adopted by the Department and without regard to any choice of an entity that the recipient might otherwise make, may initially designate a primary provider type provided that the primary provider type is willing to provide that care ~~primary care provider, primary care pharmacy, or health~~

~~maintenance organization to assume responsibility for the recipient's care, provided that the primary care provider, primary care pharmacy, or health maintenance organization is willing to provide that care~~.

(c) When the Department has requested that a recipient designate a primary provider type ~~primary care provider, primary care pharmacy or health maintenance organization~~ and the recipient fails or refuses to do so, the Department may, after a reasonable period of time, assign the recipient to a primary provider type of its own choice and determination, provided such primary provider type is willing to provide such care ~~primary care provider, primary care pharmacy or health maintenance organization of its own choice and determination, provided such primary care provider, primary care pharmacy or health maintenance organization is willing to provide such care~~.

(d) When a recipient has been restricted to a designated primary provider type ~~primary care provider, primary care pharmacy or health maintenance organization~~, the recipient may change the primary provider type ~~primary care provider, primary care pharmacy or health maintenance organization~~:

(1) when the designated source becomes unavailable, as the Department shall determine by rule; or

(2) when the designated primary provider type ~~primary care provider, primary care pharmacy or health maintenance organization~~ notifies the Department that it wishes to

withdraw from any obligation as primary provider type ~~primary care provider, primary care pharmacy or health maintenance organization~~; or

(3) in other situations, as the Department shall provide by rule.

The Department shall, by rule, establish procedures for providing medical or pharmaceutical services when the designated source becomes unavailable or wishes to withdraw from any obligation as primary provider type ~~primary care provider, primary care pharmacy or health maintenance organization~~, shall, by rule, take into consideration the need for emergency or temporary medical assistance and shall ensure that the recipient has continuous and unrestricted access to medical care from the date on which such unavailability or withdrawal becomes effective until such time as the recipient designates a primary provider type or a primary provider type ~~care source or a primary care source~~ willing to provide such care is designated by the Department consistent with subsections (b) and (c) and such restriction becomes effective.

(e) Prior to initiating any action to restrict a recipient's access to medical or pharmaceutical care, the Department shall notify the recipient of its intended action. Such notification shall be in writing and shall set forth the reasons for and nature of the proposed action. In addition, the notification shall:

(1) inform the recipient that (i) the recipient has a

right to designate a primary provider type ~~primary care provider, primary care pharmacy, or health maintenance organization~~ of the recipient's own choosing willing to accept such designation and that the recipient's failure to do so within a reasonable time may result in such designation being made by the Department or (ii) the Department has designated a primary provider type ~~primary care provider, primary care pharmacy, or health maintenance organization~~ to assume responsibility for the recipient's care; and

(2) inform the recipient that the recipient has a right to appeal the Department's determination to restrict the recipient's access to medical care and provide the recipient with an explanation of how such appeal is to be made. The notification shall also inform the recipient of the circumstances under which unrestricted medical eligibility shall continue until a decision is made on appeal and that if the recipient chooses to appeal, the recipient will be able to review the medical payment data that was utilized by the Department to decide that the recipient's access to medical care should be restricted.

(f) The Department shall, by rule or regulation, establish procedures for appealing a determination to restrict a recipient's access to medical care, which procedures shall, at a minimum, provide for a reasonable opportunity to be heard and, where the appeal is denied, for a written statement of the

reason or reasons for such denial.

(g) Except as otherwise provided in this subsection, when a recipient has had his or her medical card restricted for 4 full quarters (without regard to any period of ineligibility for medical assistance under this Code, or any period for which the recipient voluntarily terminates his or her receipt of medical assistance, that may occur before the expiration of those 4 full quarters), the Department shall reevaluate the recipient's medical usage to determine whether it is still in excess of need and with such frequency or in such a manner as to constitute an abuse of the receipt of medical assistance. If it is still in excess of need, the restriction shall be continued for another 4 full quarters. If it is no longer in excess of need, the restriction shall be discontinued. If a recipient's access to medical care has been restricted under this Section and the Department then determines, either at reevaluation or after the restriction has been discontinued, to restrict the recipient's access to medical care a second or subsequent time, the second or subsequent restriction may be imposed for a period of more than 4 full quarters. If the Department restricts a recipient's access to medical care for a period of more than 4 full quarters, as determined by rule, the Department shall reevaluate the recipient's medical usage after the end of the restriction period rather than after the end of 4 full quarters. The Department shall notify the recipient, in writing, of any decision to continue the

restriction and the reason or reasons therefor. A "quarter", for purposes of this Section, shall be defined as one of the following 3-month periods of time: January-March, April-June, July-September or October-December.

(h) In addition to any other recipient whose acquisition of medical care is determined to be in excess of need, the Department may restrict the medical care privileges of the following persons:

(1) recipients found to have loaned or altered their cards or misused or falsely represented medical coverage;

(2) recipients found in possession of blank or forged prescription pads;

(3) recipients who knowingly assist providers in rendering excessive services or defrauding the medical assistance program.

The procedural safeguards in this Section shall apply to the above individuals.

(i) Restrictions under this Section shall be in addition to and shall not in any way be limited by or limit any actions taken under Article VIII-A of this Code.

(Source: P.A. 88-554, eff. 7-26-94.)

(305 ILCS 5/5-5.15 rep.)

Section 45. The Illinois Public Aid Code is amended by repealing Section 5-5.15.

Section 50. The Illinois Vehicle Code is amended by changing Section 2-123 as follows:

(625 ILCS 5/2-123) (from Ch. 95 1/2, par. 2-123)

Sec. 2-123. Sale and Distribution of Information.

(a) Except as otherwise provided in this Section, the Secretary may make the driver's license, vehicle and title registration lists, in part or in whole, and any statistical information derived from these lists available to local governments, elected state officials, state educational institutions, and all other governmental units of the State and Federal Government requesting them for governmental purposes. The Secretary shall require any such applicant for services to pay for the costs of furnishing such services and the use of the equipment involved, and in addition is empowered to establish prices and charges for the services so furnished and for the use of the electronic equipment utilized.

(b) The Secretary is further empowered to and he may, in his discretion, furnish to any applicant, other than listed in subsection (a) of this Section, vehicle or driver data on a computer tape, disk, other electronic format or computer processable medium, or printout at a fixed fee of $250 for orders received before October 1, 2003 and $500 for orders received on or after October 1, 2003, in advance, and require in addition a further sufficient deposit based upon the Secretary of State's estimate of the total cost of the

information requested and a charge of $25 for orders received before October 1, 2003 and $50 for orders received on or after October 1, 2003, per 1,000 units or part thereof identified or the actual cost, whichever is greater. The Secretary is authorized to refund any difference between the additional deposit and the actual cost of the request. This service shall not be in lieu of an abstract of a driver's record nor of a title or registration search. This service may be limited to entities purchasing a minimum number of records as required by administrative rule. The information sold pursuant to this subsection shall be the entire vehicle or driver data list, or part thereof. The information sold pursuant to this subsection shall not contain personally identifying information unless the information is to be used for one of the purposes identified in subsection (f-5) of this Section. Commercial purchasers of driver and vehicle record databases shall enter into a written agreement with the Secretary of State that includes disclosure of the commercial use of the information to be purchased.

(b-1) The Secretary is further empowered to and may, in his or her discretion, furnish vehicle or driver data on a computer tape, disk, or other electronic format or computer processible medium, at no fee, to any State or local governmental agency that uses the information provided by the Secretary to transmit data back to the Secretary that enables the Secretary to maintain accurate driving records, including dispositions of

traffic cases. This information may be provided without fee not more often than once every 6 months.

(c) Secretary of State may issue registration lists. The Secretary of State may compile a list of all registered vehicles. Each list of registered vehicles shall be arranged serially according to the registration numbers assigned to registered vehicles and may contain in addition the names and addresses of registered owners and a brief description of each vehicle including the serial or other identifying number thereof. Such compilation may be in such form as in the discretion of the Secretary of State may seem best for the purposes intended.

(d) The Secretary of State shall furnish no more than 2 current available lists of such registrations to the sheriffs of all counties and to the chiefs of police of all cities and villages and towns of 2,000 population and over in this State at no cost. Additional copies may be purchased by the sheriffs or chiefs of police at the fee of $500 each or at the cost of producing the list as determined by the Secretary of State. Such lists are to be used for governmental purposes only.

(e) (Blank).

(e-1) (Blank).

(f) The Secretary of State shall make a title or registration search of the records of his office and a written report on the same for any person, upon written application of such person, accompanied by a fee of $5 for each registration

or title search. The written application shall set forth the intended use of the requested information. No fee shall be charged for a title or registration search, or for the certification thereof requested by a government agency. The report of the title or registration search shall not contain personally identifying information unless the request for a search was made for one of the purposes identified in subsection (f-5) of this Section. The report of the title or registration search shall not contain highly restricted personal information unless specifically authorized by this Code.

The Secretary of State shall certify a title or registration record upon written request. The fee for certification shall be $5 in addition to the fee required for a title or registration search. Certification shall be made under the signature of the Secretary of State and shall be authenticated by Seal of the Secretary of State.

The Secretary of State may notify the vehicle owner or registrant of the request for purchase of his title or registration information as the Secretary deems appropriate.

No information shall be released to the requestor until expiration of a 10 day period. This 10 day period shall not apply to requests for information made by law enforcement officials, government agencies, financial institutions, attorneys, insurers, employers, automobile associated businesses, persons licensed as a private detective or firms

licensed as a private detective agency under the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004, who are employed by or are acting on behalf of law enforcement officials, government agencies, financial institutions, attorneys, insurers, employers, automobile associated businesses, and other business entities for purposes consistent with the Illinois Vehicle Code, the vehicle owner or registrant or other entities as the Secretary may exempt by rule and regulation.

Any misrepresentation made by a requestor of title or vehicle information shall be punishable as a petty offense, except in the case of persons licensed as a private detective or firms licensed as a private detective agency which shall be subject to disciplinary sanctions under Section 40-10 of the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004.

(f-5) The Secretary of State shall not disclose or otherwise make available to any person or entity any personally identifying information obtained by the Secretary of State in connection with a driver's license, vehicle, or title registration record unless the information is disclosed for one of the following purposes:

(1) For use by any government agency, including any court or law enforcement agency, in carrying out its functions, or any private person or entity acting on behalf of a federal, State, or local agency in carrying out its

functions.

(2) For use in connection with matters of motor vehicle or driver safety and theft; motor vehicle emissions; motor vehicle product alterations, recalls, or advisories; performance monitoring of motor vehicles, motor vehicle parts, and dealers; and removal of non-owner records from the original owner records of motor vehicle manufacturers.

(3) For use in the normal course of business by a legitimate business or its agents, employees, or contractors, but only:

(A) to verify the accuracy of personal information submitted by an individual to the business or its agents, employees, or contractors; and

(B) if such information as so submitted is not correct or is no longer correct, to obtain the correct information, but only for the purposes of preventing fraud by, pursuing legal remedies against, or recovering on a debt or security interest against, the individual.

(4) For use in research activities and for use in producing statistical reports, if the personally identifying information is not published, redisclosed, or used to contact individuals.

(5) For use in connection with any civil, criminal, administrative, or arbitral proceeding in any federal, State, or local court or agency or before any

self-regulatory body, including the service of process, investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, or pursuant to an order of a federal, State, or local court.

(6) For use by any insurer or insurance support organization or by a self-insured entity or its agents, employees, or contractors in connection with claims investigation activities, antifraud activities, rating, or underwriting.

(7) For use in providing notice to the owners of towed or impounded vehicles.

(8) For use by any person licensed as a private detective or firm licensed as a private detective agency under the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004, private investigative agency or security service licensed in Illinois for any purpose permitted under this subsection.

(9) For use by an employer or its agent or insurer to obtain or verify information relating to a holder of a commercial driver's license that is required under chapter 313 of title 49 of the United States Code.

(10) For use in connection with the operation of private toll transportation facilities.

(11) For use by any requester, if the requester demonstrates it has obtained the written consent of the

individual to whom the information pertains.

(12) For use by members of the news media, as defined in Section 1-148.5, for the purpose of newsgathering when the request relates to the operation of a motor vehicle or public safety.

(13) For any other use specifically authorized by law, if that use is related to the operation of a motor vehicle or public safety.

(f-6) The Secretary of State shall not disclose or otherwise make available to any person or entity any highly restricted personal information obtained by the Secretary of State in connection with a driver's license, vehicle, or title registration record unless specifically authorized by this Code.

(g) 1. The Secretary of State may, upon receipt of a written request and a fee of $6 before October 1, 2003 and a fee of $12 on and after October 1, 2003, furnish to the person or agency so requesting a driver's record. Such document may include a record of: current driver's license issuance information, except that the information on judicial driving permits shall be available only as otherwise provided by this Code; convictions; orders entered revoking, suspending or cancelling a driver's license or privilege; and notations of accident involvement. All other information, unless otherwise permitted by this Code, shall remain confidential.

Information released pursuant to a request for a driver's record shall not contain personally identifying information, unless the request for the driver's record was made for one of the purposes set forth in subsection (f-5) of this Section. The Secretary of State may, without fee, allow a parent or guardian of a person under the age of 18 years, who holds an instruction permit or graduated driver's license, to view that person's driving record online, through a computer connection. The parent or guardian's online access to the driving record will terminate when the instruction permit or graduated driver's license holder reaches the age of 18.

2. The Secretary of State shall not disclose or otherwise make available to any person or entity any highly restricted personal information obtained by the Secretary of State in connection with a driver's license, vehicle, or title registration record unless specifically authorized by this Code. The Secretary of State may certify an abstract of a driver's record upon written request therefor. Such certification shall be made under the signature of the Secretary of State and shall be authenticated by the Seal of his office.

3. All requests for driving record information shall be made in a manner prescribed by the Secretary and shall set forth the intended use of the requested information.

The Secretary of State may notify the affected driver

of the request for purchase of his driver's record as the Secretary deems appropriate.

No information shall be released to the requester until expiration of a 10 day period. This 10 day period shall not apply to requests for information made by law enforcement officials, government agencies, financial institutions, attorneys, insurers, employers, automobile associated businesses, persons licensed as a private detective or firms licensed as a private detective agency under the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004, who are employed by or are acting on behalf of law enforcement officials, government agencies, financial institutions, attorneys, insurers, employers, automobile associated businesses, and other business entities for purposes consistent with the Illinois Vehicle Code, the affected driver or other entities as the Secretary may exempt by rule and regulation.

Any misrepresentation made by a requestor of driver information shall be punishable as a petty offense, except in the case of persons licensed as a private detective or firms licensed as a private detective agency which shall be subject to disciplinary sanctions under Section 40-10 of the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004.

4. The Secretary of State may furnish without fee, upon

the written request of a law enforcement agency, any information from a driver's record on file with the Secretary of State when such information is required in the enforcement of this Code or any other law relating to the operation of motor vehicles, including records of dispositions; documented information involving the use of a motor vehicle; whether such individual has, or previously had, a driver's license; and the address and personal description as reflected on said driver's record.

5. Except as otherwise provided in this Section, the Secretary of State may furnish, without fee, information from an individual driver's record on file, if a written request therefor is submitted by any public transit system or authority, public defender, law enforcement agency, a state or federal agency, or an Illinois local intergovernmental association, if the request is for the purpose of a background check of applicants for employment with the requesting agency, or for the purpose of an official investigation conducted by the agency, or to determine a current address for the driver so public funds can be recovered or paid to the driver, or for any other purpose set forth in subsection (f-5) of this Section.

The Secretary may also furnish the courts a copy of an abstract of a driver's record, without fee, subsequent to an arrest for a violation of Section 11-501 or a similar provision of a local ordinance. Such abstract may include

records of dispositions; documented information involving the use of a motor vehicle as contained in the current file; whether such individual has, or previously had, a driver's license; and the address and personal description as reflected on said driver's record.

6. Any certified abstract issued by the Secretary of State or transmitted electronically by the Secretary of State pursuant to this Section, to a court or on request of a law enforcement agency, for the record of a named person as to the status of the person's driver's license shall be prima facie evidence of the facts therein stated and if the name appearing in such abstract is the same as that of a person named in an information or warrant, such abstract shall be prima facie evidence that the person named in such information or warrant is the same person as the person named in such abstract and shall be admissible for any prosecution under this Code and be admitted as proof of any prior conviction or proof of records, notices, or orders recorded on individual driving records maintained by the Secretary of State.

7. Subject to any restrictions contained in the Juvenile Court Act of 1987, and upon receipt of a proper request and a fee of $6 before October 1, 2003 and a fee of $12 on or after October 1, 2003, the Secretary of State shall provide a driver's record to the affected driver, or the affected driver's attorney, upon verification. Such

record shall contain all the information referred to in paragraph 1 of this subsection (g) plus: any recorded accident involvement as a driver; information recorded pursuant to subsection (e) of Section 6-117 and paragraph (4) of subsection (a) of Section 6-204 of this Code. All other information, unless otherwise permitted by this Code, shall remain confidential.

(h) The Secretary shall not disclose social security numbers or any associated information obtained from the Social Security Administration except pursuant to a written request by, or with the prior written consent of, the individual except: (1) to officers and employees of the Secretary who have a need to know the social security numbers in performance of their official duties, (2) to law enforcement officials for a lawful, civil or criminal law enforcement investigation, and if the head of the law enforcement agency has made a written request to the Secretary specifying the law enforcement investigation for which the social security numbers are being sought, (3) to the United States Department of Transportation, or any other State, pursuant to the administration and enforcement of the Commercial Motor Vehicle Safety Act of 1986, (4) pursuant to the order of a court of competent jurisdiction, (5) to the Department of Healthcare and Family Services (formerly Department of Public Aid) for utilization in the child support enforcement duties assigned to that Department under provisions of the Illinois Public Aid Code after the

individual has received advanced meaningful notification of what redisclosure is sought by the Secretary in accordance with the federal Privacy Act, (5.5) to the Department of Healthcare and Family Services and the Department of Human Services solely for the purpose of verifying Illinois residency where such residency is an eligibility requirement for benefits under the Illinois Public Aid Code or any other health benefit program administered by the Department of Healthcare and Family Services or the Department of Human Services, or (6) to the Illinois Department of Revenue solely for use by the Department in the collection of any tax or debt that the Department of Revenue is authorized or required by law to collect, provided that the Department shall not disclose the social security number to any person or entity outside of the Department.

(i) (Blank).

(j) Medical statements or medical reports received in the Secretary of State's Office shall be confidential. No confidential information may be open to public inspection or the contents disclosed to anyone, except officers and employees of the Secretary who have a need to know the information contained in the medical reports and the Driver License Medical Advisory Board, unless so directed by an order of a court of competent jurisdiction.

(k) All fees collected under this Section shall be paid into the Road Fund of the State Treasury, except that (i) for fees collected before October 1, 2003, $3 of the $6 fee for a

driver's record shall be paid into the Secretary of State Special Services Fund, (ii) for fees collected on and after October 1, 2003, of the $12 fee for a driver's record, $3 shall be paid into the Secretary of State Special Services Fund and $6 shall be paid into the General Revenue Fund, and (iii) for fees collected on and after October 1, 2003, 50% of the amounts collected pursuant to subsection (b) shall be paid into the General Revenue Fund.

(l) (Blank).

(m) Notations of accident involvement that may be disclosed under this Section shall not include notations relating to damage to a vehicle or other property being transported by a tow truck. This information shall remain confidential, provided that nothing in this subsection (m) shall limit disclosure of any notification of accident involvement to any law enforcement agency or official.

(n) Requests made by the news media for driver's license, vehicle, or title registration information may be furnished without charge or at a reduced charge, as determined by the Secretary, when the specific purpose for requesting the documents is deemed to be in the public interest. Waiver or reduction of the fee is in the public interest if the principal purpose of the request is to access and disseminate information regarding the health, safety, and welfare or the legal rights of the general public and is not for the principal purpose of gaining a personal or commercial benefit. The information

provided pursuant to this subsection shall not contain personally identifying information unless the information is to be used for one of the purposes identified in subsection (f-5) of this Section.

(o) The redisclosure of personally identifying information obtained pursuant to this Section is prohibited, except to the extent necessary to effectuate the purpose for which the original disclosure of the information was permitted.

(p) The Secretary of State is empowered to adopt rules to effectuate this Section.

(Source: P.A. 95-201, eff. 1-1-08; 95-287, eff. 1-1-08; 95-331, eff. 8-21-07; 95-613, eff. 9-11-07; 95-876, eff. 8-21-08; 96-1383, eff. 1-1-11.)

Section 95. Severability. If any provision of this Act or application thereof to any person or circumstance is held invalid, such invalidity does not affect other provisions or applications of this Act which can be given effect without the invalid application or provision, and to this end the provisions of this Act are declared to be severable.

Section 99. Effective date. This Act takes effect upon becoming law.".