Rep. Sara Feigenholtz

Filed: 5/21/2012

AMENDMENT TO SENATE BILL 2840

AMENDMENT NO. _____. Amend Senate Bill 2840 by replacing everything after the enacting clause with the following:

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

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

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

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

Sec. 5-45. Emergency rulemaking.

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

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

(c) An emergency rule may be effective for a period of not

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

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

except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

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

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

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

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

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

this subsection (h) shall be deemed to be necessary for the public interest, safety, and welfare.

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

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

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

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

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year

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

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

(n) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year

2010 budget, emergency rules to implement any provision of this amendatory Act of the 96th General Assembly or any other budget initiative authorized by the 96th General Assembly for fiscal year 2010 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (n) shall be deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (n) shall apply only to rules promulgated during Fiscal Year 2010.

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

(p) In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 97th General Assembly, emergency rules to implement any

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

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

Section 11. The Civil Administrative Code of Illinois is amended by changing Section 5-235 as follows:

(20 ILCS 5/5-235) (was 20 ILCS 5/7.03)

Sec. 5-235. In the Department of Public Health.

(a) The Director of Public Health shall be either a physician licensed to practice medicine in all of its branches in Illinois or a person who has administrative experience in public health work at the local, state, or national level in accordance with subsection (b).

If the Director is not a physician licensed to practice medicine in all its branches, then a Medical Director ~~The~~

~~Assistant Director of Public Health~~ shall be appointed who shall be a physician licensed to practice medicine in all its branches ~~a person who has administrative experience in public health work~~. The Medical Director shall report directly to the Director. If the Director is not a physician, the Medical Director shall have primary responsibility for overseeing the following regulatory and policy areas:

(1) Department responsibilities concerning hospital and health care facility regulation, emergency services, ambulatory surgical treatment centers, health care professional regulation and credentialing, advising the Board of Health, patient safety initiatives, and the State's response to disease prevention and outbreak management and control.

(2) Any other duties assigned by the Director or required by law.

(b) A Director of Public Health who is not a physician licensed to practice medicine in all its branches shall at a minimum have the following education and experience:

(1) 5 years of full-time administrative experience in public health and a master's degree in public health from (i) a college or university accredited by the North Central Association or (ii) any other nationally recognized regional accrediting agency; or

(2) 5 years of full-time administrative experience in public health and a graduate degree in a related field from

(i) a college or university accredited by the North Central Association or (ii) any other nationally recognized regional accrediting agency. (For the purposes of this item (2), "a graduate degree in a related field" includes, but is not limited to, a master's degree in public administration, nursing, environmental health, community health, or health education.

(c) The Assistant Director of Public Health shall be a person who has administrative experience in public health work.

(Source: P.A. 91-239, eff. 1-1-00.)

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

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

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

(1) In each department, board or commission that now maintains or may hereafter maintain a major administrative division, service or office in both Sangamon County and Cook County, 2 private secretaries for the director or chairman thereof, one located in the Cook County office and the other located in the Sangamon County office, shall be exempt from jurisdiction B; in all other departments,

boards and commissions one private secretary for the director or chairman thereof shall be exempt from jurisdiction B. In all departments, boards and commissions one confidential assistant for the director or chairman thereof shall be exempt from jurisdiction B. This paragraph is subject to such modifications or waiver of the exemptions as may be necessary to assure the continuity of federal contributions in those agencies supported in whole or in part by federal funds.

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

(3) The Civil Service Commission, upon written recommendation of the Director of Central Management Services, shall exempt from jurisdiction B other positions which, in the judgment of the Commission, involve either principal administrative responsibility for the determination of policy or principal administrative responsibility for the way in which policies are carried out, except positions in agencies which receive federal funds if such exemption is inconsistent with federal requirements, and except positions in agencies supported in whole by federal funds.

(4) All beauticians and teachers of beauty culture and teachers of barbering, and all positions heretofore paid

under Section 1.22 of "An Act to standardize position titles and salary rates", approved June 30, 1943, as amended, shall be exempt from jurisdiction B.

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

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

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

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

(A) HEALTHCARE ADMINISTRATION.

Medical Director: Licensed Medical Doctor in good standing; experience in healthcare payment systems, pay for performance initiatives, medical necessity criteria or federal or State quality improvement programs; preferred experience serving

Medicaid patients or experience in population health programs with a large provider, health insurer, government agency, or research institution.

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

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

Quality Management Bureau: Manager, Primary Care Provider Quality and Practice Development: Clinical degree or advanced degree in relevant field required; experience in practice administration in the primary care setting with a provider or a provider association or an accrediting body; knowledge of practice standards for medical homes and best evidence based standards of care for primary care.

Director of Care Coordination Contracts and Compliance: Bachelor's degree required; multi-year

experience in negotiating managed care contracts, preferably on behalf of a payer; experience with health care contract compliance.

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

Manager, Behavioral Health Programs: Clinical license or Advanced degree required, preferably in psychology, social work, or relevant field; knowledge of medical necessity criteria and governmental policies and regulations governing the provision of mental health services to Medicaid populations, including children and adults, in community and institutional settings of care. The General Assembly finds that this position is necessary for the timely and effective implementation of this amendatory Act of the 97th

General Assembly.

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

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

Director of Dental Program: Bachelor's degree required, advanced degree preferred, in healthcare management or relevant field; experience in healthcare administration; experience in administering dental healthcare programs, knowledge of practice standards for dental care and treatment services; knowledge of the public

dental health infrastructure.

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

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

(B) HEALTHCARE FINANCE.

Director of Care Coordination Rate and Finance: MBA, CPA, or Actuarial degree required; experience in managed care rate setting, including, but not limited to, baseline costs and growth trends; knowledge and experience with Medical Loss Ratio standards and measurements.

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

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

Manager of Medical Finance, Division of Finance: Requires relevant advanced degree or certification in relevant field, such as Certified Public Accountant; coursework in business or public administration, accounting, finance, data analysis, or statistics preferred; experience in control systems and GAAP; financial management experience in a healthcare or government entity utilizing Medicaid funding.

(C) HEALTHCARE DATA ANALYTICS.

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

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

Data Analytics Platform Manager: Bachelor's degree required, advanced degree preferred, preferably in business or information systems; extensive healthcare data reporting experience

with a large provider, health insurer, government agency, or research institution; previous experience working on a health insurance data analytics platform; experience managing contracts and vendors preferred.

(D) HEALTHCARE INFORMATION TECHNOLOGY.

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

Manager of MMIS Claims Unit: Bachelor's degree required, with preferred coursework in business, public administration, information systems; experience equivalent to 4 years of administration in a public or business organization; working knowledge with design and implementation of technical solutions to medical claims payment systems; extensive technical writing experience, including, but not limited to, the development of RFPs, APDs, feasibility studies, and related documents; thorough knowledge of IT system design, commercial off the shelf software packages and hardware components.

Assistant Bureau Chief, Office of Information

Systems: Bachelor's degree required, with preferred coursework in business, public administration, information systems; experience equivalent to 5 years of administration in a public or private business organization; extensive technical writing experience, including, but not limited to, the development of RFPs, APDs, feasibility studies and related documents; extensive healthcare technology experience with a large provider, health insurer, government agency, or research institution; experience as a business analyst interfacing between business and information technology departments; thorough knowledge of IT system design, commercial off the shelf software packages and hardware components.

Technical System Architect: Bachelor's degree required, with preferred coursework in computer science or information technology; prior experience equivalent to 5 years of computer science or IT administration in a public or business organization; extensive healthcare technology experience with a large provider, health insurer, government agency, or research institution; experience as a business analyst interfacing between business and information technology departments.

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

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

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

(30 ILCS 5/2-20 new)

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

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

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

(c) No later than May 1, 2013, the Auditor General shall submit a report to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the Senate President, and the Senate Minority

Leader as to whether the Department has undertaken the required actions listed in the report required by subsection (a).

Section 15. The State Finance Act is amended by changing Sections 6z-52, 13.2, and 25 as follows:

(30 ILCS 105/6z-52)

Sec. 6z-52. Drug Rebate Fund.

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

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

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

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

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

(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.

The ~~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; 96-1501, eff. 1-25-11.)

(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-2.5) All outstanding liabilities as of June 30, 2011, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2011, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring

appropriations until December 31, 2011, without regard to the fiscal year in which the payment is made, as long as vouchers for the liabilities are received by the Comptroller no later than August 31, 2011.

(b-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 <u>(or successor agency)</u> 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 and ~~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 (or successor agency) 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.

(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 and ~~,~~ 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.

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

(1) Definition of Medical Assistance.

For purposes of this subsection, the term "Medical Assistance" shall include, but not necessarily be limited to, medical programs and services authorized under Titles XIX and XXI of the Social Security Act, the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, the Long Term Acute Care Hospital Quality Improvement Transfer Program Act, and medical care to or on behalf of persons suffering from chronic renal disease, persons suffering from hemophilia and victims of sexual assault.

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

(A) The maximum amounts of annual unpaid Medical Assistance bills received and recorded by the

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

(B) Bills for Medical Assistance services rendered in a particular fiscal year, but received and recorded by the Department of Healthcare and Family Services after June 30th of that fiscal year, may be paid from either appropriations for that fiscal year or future fiscal year appropriations for Medical Assistance. Such payments shall not be subject to the requirements of subparagraph (A).

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

(D) Medical Assistance payments made by the

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

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

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

(Source: P.A. 96-928, eff. 6-15-10; 96-958, eff. 7-1-10; 96-1501, eff. 1-25-11; 97-75, eff. 6-30-11; 97-333, eff. 8-12-11.)

(30 ILCS 105/5.441 rep.)

(30 ILCS 105/5.442 rep.)

(30 ILCS 105/5.549 rep.)

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

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

(30 ILCS 500/1-10)

Sec. 1-10. Application.

(a) This Code applies only to procurements for which contractors were first solicited on or after July 1, 1998. This Code shall not be construed to affect or impair any contract, or any provision of a contract, entered into based on a solicitation prior to the implementation date of this Code as described in Article 99, including but not limited to any covenant entered into with respect to any revenue bonds or similar instruments. All procurements for which contracts are solicited between the effective date of Articles 50 and 99 and July 1, 1998 shall be substantially in accordance with this Code and its intent.

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

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

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

(3) Purchase of care.

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

(5) Collective bargaining contracts.

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

(7) Contracts necessary to prepare for anticipated litigation, enforcement actions, or investigations, provided that the chief legal counsel to the Governor shall give his or her prior approval when the procuring agency is one subject to the jurisdiction of the Governor, and provided that the chief legal counsel of any other procuring entity subject to this Code shall give his or her

prior approval when the procuring entity is not one subject to the jurisdiction of the Governor.

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

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

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

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

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

(d) Except for Section 20-160 and Article 50 of this Code,

and as expressly required by Section 9.1 of the Illinois Lottery Law, the provisions of this Code do not apply to the procurement process provided for under Section 9.1 of the Illinois Lottery Law.

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

(f) This Code does not apply to the process used by the Illinois Power Agency to retain a mediator to mediate sourcing agreement disputes between gas utilities and the clean coal SNG brownfield facility, as defined in Section 1-10 of the Illinois Power Agency Act, as required under subsection (h-1) of Section 9-220 of the Public Utilities Act.

(g) ~~(e)~~ This Code does not apply to the processes used by the Illinois Power Agency to retain a mediator to mediate contract disputes between gas utilities and the clean coal SNG facility and to retain an expert to assist in the review of contracts under subsection (h) of Section 9-220 of the Public

Utilities Act. This Code does not apply to the process used by the Illinois Commerce Commission to retain an expert to assist in determining the actual incurred costs of the clean coal SNG facility and the reasonableness of those costs as required under subsection (h) of Section 9-220 of the Public Utilities Act.

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

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

(30 ILCS 775/Act rep.)

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

Section 45. The Nursing Home Care Act is amended by changing Section 3-202.05 as follows:

(210 ILCS 45/3-202.05)

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

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

(1) registered nurses;

(2) licensed practical nurses;

(3) certified nurse assistants;

(4) psychiatric services rehabilitation aides;

(5) rehabilitation and therapy aides;

(6) psychiatric services rehabilitation coordinators;

(7) assistant directors of nursing;

(8) 50% of the Director of Nurses' time; and

(9) 30% of the Social Services Directors' time.

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

Within 120 days of the effective date of this amendatory Act of the 97th General Assembly, the Department shall promulgate rules specific to the staffing requirements for facilities federally defined as Institutions for Mental Disease. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

Within 120 days of the effective date of this amendatory Act of the 97th General Assembly, the Department shall

promulgate rules specific to the staffing requirements for facilities licensed under the Specialized Mental Health Rehabilitation Act. These rules shall recognize the unique nature of individuals with chronic mental health conditions, shall include minimum requirements for specialized clinical staff, including clinical social workers, psychiatrists, psychologists, and direct care staff set forth in paragraphs (4) through (6) and any other specialized staff which may be utilized and deemed necessary to count toward staffing ratios.

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

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

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

(2) Effective January 1, 2011, the minimum staffing ratios shall be increased to 2.7 hours of nursing and personal care

each day for a resident needing skilled care and 1.9 hours of nursing and personal care each day for a resident needing intermediate care.

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

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

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

(e) Ninety days after the effective date of this amendatory Act of the 97th General Assembly, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. These minimum requirements shall remain in effect until an acuity based registered nurse requirement is promulgated by rule concurrent with the adoption of the Resource Utilization Group classification-based payment

methodology, as provided in Section 5-5.2 of the Illinois Public Aid Code. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. Notwithstanding this subsection, no staffing requirement in statute in effect on the effective date of this amendatory Act of the 97th General Assembly shall be reduced on account of this subsection.

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

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

(210 ILCS 50/3.86)

Sec. 3.86. Stretcher van providers.

(a) In this Section, "stretcher van provider" means an entity licensed by the Department to provide non-emergency transportation of passengers on a stretcher in compliance with this Act or the rules adopted by the Department pursuant to this Act, utilizing stretcher vans.

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

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

(2) Establish licensing and safety standards and requirements for stretcher van providers, through rules

adopted pursuant to this Act, including but not limited to:

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

(B) Safety equipment requirements and standards.

(C) Staffing requirements.

(D) Annual license renewal.

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

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

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

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

issued.

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

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

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

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

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

(3) He or she needs routine transportation to or from a medical appointment or service if the passenger is convalescent or otherwise bed-confined and does not require clinical observation ~~medical monitoring~~, aid, care, or treatment during transport.

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

(1) He or she is being transported to a hospital for emergency medical treatment. ~~He or she is currently~~

~~admitted to a hospital or is being transported to a hospital for admission or emergency treatment.~~

(2) He or she has a medical condition that requires active medical monitoring, medical care, medical treatment, or clinical observation during transport by a licensee designated under this Act. ~~He or she is acutely ill, wounded, or medically unstable as determined by a licensed physician.~~

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

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

~~(5) He or she was moved from one environment where 24 hour medical monitoring or medical observation will take place by certified or licensed nursing personnel to another such environment. Such environments shall include, but not be limited to, hospitals licensed under the Hospital Licensing Act or operated under the University of Illinois Hospital Act, and nursing facilities licensed under the Nursing Home Care Act.~~

(c) A stretcher van provider may not transport a passenger who meets any of the following criteria:

(1) He or she is being transported to a hospital for emergency medical treatment;

(2) He or she is experiencing an emergency medical

condition or needs active medical monitoring, including isolation precautions, supplemental oxygen that is not self-administered, continuous airway management, suctioning during transport, or the administration of intravenous fluids during transport.

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

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

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

(210 ILCS 155/35)

Sec. 35. LTAC supplemental per diem rate.

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

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

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

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

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

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

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

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

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

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

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

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

(3) The LTAC hospital's Medicaid Percentage Adjustment

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

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

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

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

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

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

(210 ILCS 155/40)

Sec. 40. Rate adjustments for quality measures.

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

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

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

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

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

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

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

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

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

(210 ILCS 155/45)

Sec. 45. Program evaluation.

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

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

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

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

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

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

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

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

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

(210 ILCS 155/55 new)

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

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

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

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

(215 ILCS 106/25)

Sec. 25. Health benefits for children.

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

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

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

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

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

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

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

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

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

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

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

(215 ILCS 106/40)

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

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

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

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

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

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

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

(215 ILCS 170/30)

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

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

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

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

(215 ILCS 170/35)

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

Sec. 35. Health care benefits for children.

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

transportation.

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

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

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

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

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

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

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

Section 75. The Illinois Public Aid Code is amended by changing Sections 3-1.2, 5-1.4, 5-2, 5-2.03, 5-4, 5-4.1, 5-4.2, 5-5, 5-5.02, 5-5.05, 5-5.2, 5-5.3, 5-5.4, 5-5.4e, 5-5.5, 5-5.8b, 5-5.12, 5-5.17, 5-5.20, 5-5.23, 5-5.24, 5-5.25, 5-16.7, 5-16.7a, 5-16.8, 5-16.9, 5-17, 5-19, 5-24, 5-30, 5A-1, 5A-2, 5A-3, 5A-4, 5A-5, 5A-6, 5A-8, 5A-10, 5A-12.2, 5A-14, 6-11, 11-13, 11-26, 12-4.25, 12-4.38, 12-4.39, 12-10.5, 12-13.1, 14-8, 15-1, 15-2, 15-5, and 15-11 and by adding Sections 5-2b, 5-2.1d, 5-5e, 5-5e.1, 5-5f, 5A-15, 11-5.2, 11-5.3, and 14-11 as follows:

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

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

In determining earned income to be taken into account, consideration shall be given to any expenses reasonably attributable to the earning of such income. If federal law or regulations permit or require exemption of earned or other

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

determine whether the 6% rule is met, and then the amounts of the person's equity in all of those properties shall be totaled to determine whether the total equity is $6,000 or less. The total equity value of all properties that is exempt shall be limited to $6,000.

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

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

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

(2) Funds in an irrevocable prepaid funeral or burial contract are exempt up to $5,874, except that any portion

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

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

person. The trust is responsible for ensuring that the provider of funeral services under the contract receives the proceeds of the policy when it provides the funeral goods and services specified under the contract. The irrevocable assignment of ownership of the insurance policy must be acknowledged by the insurance company.

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

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

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

Occasional or irregular gifts in cash, goods or services from persons who are not legally responsible relatives which are of nominal value or which do not have significant effect in meeting essential requirements shall be disregarded. The eligibility of any applicant for or recipient of public aid

under this Article is not affected by the payment of any grant under the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

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

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

(305 ILCS 5/5-1.4)

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 or to expansions approved by the federal government that are financed entirely by units of local government and federal matching funds. If the State of Illinois finds that the State has borne a cost related to such an expansion, the unit of local government shall reimburse the State. All federal funds associated with an expansion funded by a unit of local government shall be returned to the unit of local government funding the expansion, pursuant to an intergovernmental agreement between the Department of Healthcare and Family Services and the unit of local government. Within 10 calendar days of the effective date of this amendatory Act of the 97th General Assembly, the Department of Healthcare and Family Services shall formally advise the Centers for Medicare and Medicaid Services of the passage of this amendatory Act of the 97th General Assembly. The State is prohibited from submitting additional waiver requests that expand or allow for an increase in the classes of persons eligible for medical assistance under this Article to the federal government for its consideration beginning on the 20th calendar day following the effective date of this amendatory Act of the 97th General Assembly until January 25, 2013.

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

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

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

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

2. Persons otherwise eligible for basic maintenance under Articles III and IV, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, but who fail to qualify thereunder on the basis of need or who qualify but are not receiving basic maintenance under Article IV, and who have insufficient income and resources to meet the costs of necessary medical care, including but not limited to the following:

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

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in

fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size; or

(ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined in item (i) of this subparagraph (a).

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

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

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

5.(a) Women during pregnancy, after the fact of pregnancy has been determined by medical diagnosis, and during the 60-day period beginning on the last day of the pregnancy, together with their infants and children born after September 30, 1983, whose income and resources are insufficient to meet the costs of necessary medical care to the maximum extent possible under Title XIX of the Federal Social Security Act.

(b) The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 5(a) by April 1, 1990. Such plan shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 133% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size, provided that costs incurred for medical care

are not taken into account in determining such income eligibility.

(c) The Illinois Department may conduct a demonstration in at least one county that will provide medical assistance to pregnant women, together with their infants and children up to one year of age, where the income eligibility standard is set up to 185% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those established under Article IV of this Code.

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

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

~~(a) the person requires a level of care provided by~~

~~a hospital, skilled nursing facility, or intermediate care facility, as determined by a physician licensed to practice medicine in all its branches;~~

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

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

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

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

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

(i) such coverage shall be pursuant to

provisions of the federal Social Security Act;

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

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

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

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

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the

qualifications for protection of resources described in Section 15 of that Act.

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

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

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

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

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

12. Subject to federal approval, persons who are

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

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

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

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

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this

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

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

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and

(i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

(a) On and after July 1, 2012 ~~Through December 31, 2013~~, a caretaker relative who is 19 years of age or older when countable income is at or below 133% ~~185%~~ of the Federal Poverty Level Guidelines, as published annually in the Federal Register, for the appropriate family size. ~~Beginning January 1, 2014, a caretaker relative who is 19 years of age or older when countable income is at or below 133% of the Federal Poverty Level~~

~~Guidelines, as published annually in the Federal Register, for the appropriate family size.~~ A person may not spend down to become eligible under this paragraph 15.

(b) Eligibility shall be reviewed annually.

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

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

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

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

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

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

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

re-enrolled. ~~following action is required before the individual can be re-enrolled:~~

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

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

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

~~The Department is authorized to implement the provisions of this amendatory Act of the 95th General Assembly by adopting the medical assistance rules in effect as of October 1, 2007, at 89 Ill. Admin. Code 125, and at 89 Ill. Admin. Code 120.32 along with only those changes necessary to conform to federal Medicaid requirements, federal laws, and federal regulations, including but not limited to Section 1931 of the Social Security Act (42 U.S.C. Sec. 1396u-1), as interpreted by the U.S. Department of Health and Human Services, and the countable income eligibility standard authorized by this paragraph 15. The Department may not otherwise adopt any rule to implement~~

~~this increase except as authorized by law, to meet the eligibility standards authorized by the federal government in the Medicaid State Plan or the Title XXI Plan, or to meet an order from the federal government or any court.~~

16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16. Such persons shall be eligible for medical assistance under this paragraph 16 for so long as they need treatment for the cancer. A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or testicular cancer, including recurrent metastatic cancer that is a known or

presumed complication of prostate or testicular cancer and complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need treatment. "Medical assistance" under this paragraph 16 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a claim against the estate of a deceased recipient of services under this paragraph 16 and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16.

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

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

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

assistance under this Article.

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

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

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

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

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

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

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

Notwithstanding any other provision of this Code, if the United States Supreme Court holds Title II, Subtitle A, Section 2001(a) of Public Law 111-148 to be unconstitutional, or if a holding of Public Law 111-148 makes Medicaid eligibility allowed under Section 2001(a) inoperable, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after the effective date of this amendatory Act of the 97th General Assembly, and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately

ineligible.

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

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

(305 ILCS 5/5-2b new)

Sec. 5-2b. Medically fragile and technology dependent children eligibility and program. Notwithstanding any other provision of law, on and after September 1, 2012, subject to federal approval, medical assistance under this Article shall be available to children who qualify as persons with a disability, as defined under the federal Supplemental Security Income program and who are medically fragile and technology dependent. The program shall allow eligible children to receive

the medical assistance provided under this Article in the community, shall be limited to families with income up to 500% of the federal poverty level, and must maximize, to the fullest extent permissible under federal law, federal reimbursement and family cost-sharing, including co-pays, premiums, or any other family contributions, except that the Department shall be permitted to incentivize the utilization of selected services through the use of cost-sharing adjustments. The Department shall establish the policies, procedures, standards, services, and criteria for this program by rule.

(305 ILCS 5/5-2.03)

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 or to persons enrolled under the medical assistance program due to expansions approved by the federal government that are financed entirely by units of local government and federal matching funds.

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

(305 ILCS 5/5-2.1d new)

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

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

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

(a) The amount and nature of medical assistance shall be determined ~~by the County Departments~~ in accordance with the standards, rules, and regulations of the Department of Healthcare and Family Services, with due regard to the requirements and conditions in each case, including contributions available from legally responsible relatives. However, the amount and nature of such medical assistance shall not be affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief ~~and~~

~~Pharmaceutical Assistance~~ Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The amount and nature of medical assistance shall not be affected by the receipt of donations or benefits from fundraisers in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

In determining the income and resources ~~assets~~ available to the institutionalized spouse and to the community spouse, the Department of Healthcare and Family Services shall follow the procedures established by federal law. If an institutionalized spouse or community spouse refuses to comply with the requirements of Title XIX of the federal Social Security Act and the regulations duly promulgated thereunder by failing to provide the total value of assets, including income and resources, to the extent either the institutionalized spouse or community spouse has an ownership interest in them pursuant to 42 U.S.C. 1396r-5, such refusal may result in the institutionalized spouse being denied eligibility and continuing to remain ineligible for the medical assistance program based on failure to cooperate.

Subject to federal approval, the ~~The~~ community spouse resource allowance shall be established and maintained at the minimum ~~maximum~~ level permitted pursuant to Section 1924(f)(2)

of the Social Security Act, as now or hereafter amended, or an amount set after a fair hearing, whichever is greater. The monthly maintenance allowance for the community spouse shall be established and maintained at the minimum ~~maximum~~ level permitted pursuant to Section 1924(d)(3)(C) of the Social Security Act, as now or hereafter amended. Subject to the approval of the Secretary of the United States Department of Health and Human Services, the provisions of this Section shall be extended to persons who but for the provision of home or community-based services under Section 4.02 of the Illinois Act on the Aging, would require the level of care provided in an institution, as is provided for in federal law.

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

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

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

(iii) Proceedings may be initiated to obtain support,

or for the recovery of aid granted during the period such support was not provided, or both, for the obtainment of support and the recovery of the aid provided. Proceedings for the recovery of aid may be taken separately or they may be consolidated with actions to obtain support. Such proceedings may be brought in the name of the person or persons requiring support or may be brought in the name of the Department, as the case requires.

(iv) The orders for the payment of moneys for the support of the person shall be just and equitable and may direct payment thereof for such period or periods of time as the circumstances require, including support for a period before the date the order for support is entered. In no event shall the orders reduce the community spouse resource allowance below the level established in subsection (a) of this Section or an amount set after a fair hearing, whichever is greater, or reduce the monthly maintenance allowance for the community spouse below the level permitted pursuant to subsection (a) of this Section.

~~The Department of Human Services shall notify in writing each institutionalized spouse who is a recipient of medical assistance under this Article, and each such person's community spouse, of the changes in treatment of income and resources, including provisions for protecting income for a community spouse and permitting the transfer of resources to a community spouse, required by enactment of the federal Medicare~~

~~Catastrophic Coverage Act of 1988 (Public Law 100-360). The notification shall be in language likely to be easily understood by those persons. The Department of Human Services also shall reassess the amount of medical assistance for which each such recipient is eligible as a result of the enactment of that federal Act, whether or not a recipient requests such a reassessment.~~

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

(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, except that the Department shall impose a co-pay of $2 on generic drugs. 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 $10 for emergency room use for a non-emergency situation as defined by the Department by rule and subject to federal approval.

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

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

Sec. 5-4.2. Ambulance services payments.

(a) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1993, the Illinois Department shall reimburse ambulance service providers at rates calculated in accordance with this Section. It is the intent of the General Assembly to provide adequate reimbursement for ambulance services so as to ensure adequate access to services for recipients of aid under this Article and to provide appropriate incentives to ambulance service providers to provide services in an efficient and cost-effective manner. Thus, it is the intent of the General Assembly that the Illinois Department implement a reimbursement system for ambulance services that, to the extent

practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, is consistent with the payment principles of Medicare. To ensure uniformity between the payment principles of Medicare and Medicaid, the Illinois Department shall follow, to the extent necessary and practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, the statutes, laws, regulations, policies, procedures, principles, definitions, guidelines, and manuals used to determine the amounts paid to ambulance service providers under Title XVIII of the Social Security Act (Medicare).

(b) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1996, the Illinois Department shall reimburse ambulance service providers based upon the actual distance traveled if a natural disaster, weather conditions, road repairs, or traffic congestion necessitates the use of a route other than the most direct route.

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

(c-1) For purposes of this Section, "ground ambulance service" means medical transportation services that are described as ground ambulance services by the Centers for Medicare and Medicaid Services and provided in a vehicle that is licensed as an ambulance by the Illinois Department of

Public Health pursuant to the Emergency Medical Services (EMS) Systems Act.

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

(d) This Section does not prohibit separate billing by ambulance service providers for oxygen furnished while providing advanced life support services.

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver

and, as applicable, employee attendant that actually transported the patient. Providers must recertify all drivers and employee attendants every 3 years.

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

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service

requested. The rule shall be filed by December 15, 2012 ~~established within 12 months after the effective date of this amendatory Act of the 97th General Assembly~~ and shall provide that, for any decision rendered by the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(g) Whenever a patient covered by a medical assistance program under this Code or by another medical program administered by the Department is being discharged from a facility, a physician discharge order as described in this Section shall be required for each patient whose discharge requires medically supervised ground ambulance services. Facilities shall develop procedures for a physician with medical staff privileges to provide a written and signed physician discharge order. The physician discharge order shall specify the level of ground ambulance services needed and complete a medical certification establishing the criteria for approval of non-emergency ambulance transportation, as published by the Department of Healthcare and Family Services, that is met by the patient. This order and the medical

certification shall be completed prior to ordering an ambulance service and prior to patient discharge.

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

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

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

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home,

or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, for children and adults; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature

births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

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

other appropriate requirements regarding laboratory test order documentation.

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

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

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

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

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

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

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

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

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

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

(D) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates

heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

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

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

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

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other

hospital-based mammography facilities.

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

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

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

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of drug abuse or is addicted as defined in the Alcoholism and Other Drug Abuse and Dependency

Act, referral to a local substance abuse treatment provider licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

All medical providers providing medical assistance to pregnant women under this Code shall receive information from the Department on the availability of services under the Drug Free Families with a Future or any comparable program providing case management services for addicted women, including information on appropriate referrals for other social services that may be needed by addicted women in addition to treatment for addiction.

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

Neither the Department of Healthcare and Family Services nor the Department of Human Services shall sanction the

recipient solely on the basis of her substance abuse.

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

~~Notwithstanding any other provision of law, a health care provider under the medical assistance program may elect, in lieu of receiving direct payment for services provided under that program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of the Illinois Pension Code. A health care provider who elects to participate in the plan does not have a cause of action against the State for any damages allegedly suffered by the provider as a result of any delay by the State in crediting the amount of any contribution to the provider's plan account.~~

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

shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

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

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

Medical providers shall be required to meet certain

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

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that

if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this

amendatory Act of 1984, the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

The Illinois Department may require that all dispensers of medical services desiring to participate in the medical assistance program established under this Article disclose, under such terms and conditions as the Illinois Department may

by rule establish, all inquiries from clients and attorneys regarding medical bills paid by the Illinois Department, which inquiries could indicate potential existence of claims or liens for the Illinois Department.

Enrollment of a vendor ~~that provides non-emergency medical transportation, defined by the Department by rule,~~ shall be subject to a provisional period and shall be conditional for one year ~~180 days~~. During the period of conditional enrollment ~~that time~~, the Department ~~of Healthcare and Family Services~~ may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause. Unless otherwise specified, such ~~That~~ termination of eligibility or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

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

Prior to enrollment and during the conditional enrollment period in the medical assistance program, all vendors shall be subject to enhanced oversight, screening, and review based on the risk of fraud, waste, and abuse that is posed by the category of risk of the vendor. The Illinois Department shall establish the procedures for oversight, screening, and review, which may include, but need not be limited to: criminal and financial background checks; fingerprinting; license,

certification, and authorization verifications; unscheduled or unannounced site visits; database checks; prepayment audit reviews; audits; payment caps; payment suspensions; and other screening as required by federal or State law.

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

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

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

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

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

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

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

Claims that are not submitted and received in compliance

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

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

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

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

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or

replacement of such devices by recipients ~~without medical authorization~~; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such ~~Such~~ rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

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

effectuate a similar savings amount for this population; and (iv) no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests.

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

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

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

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

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

(d) efforts at utilization review and control by the

Illinois Department.

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The filing of one copy of the report with the Speaker, one copy with the Minority Leader and one copy with the Clerk of the House of Representatives, one copy with the President, one copy with the Minority Leader and one copy with the Secretary of the Senate, one copy with the Legislative Research Unit, and such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act shall be deemed sufficient to comply with this Section.

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

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

(Source: P.A. 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926,

eff. 1-1-11; 96-1000, eff. 7-2-10; 97-48, eff. 6-28-11; 97-638, eff. 1-1-12.)

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

Sec. 5-5.02. Hospital reimbursements.

(a) Reimbursement to Hospitals; July 1, 1992 through September 30, 1992. Notwithstanding any other provisions of this Code or the Illinois Department's Rules promulgated under the Illinois Administrative Procedure Act, reimbursement to hospitals for services provided during the period July 1, 1992 through September 30, 1992, shall be as follows:

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

(2) For the purpose of calculating the inpatient

payment rate for each hospital eligible to receive quarterly adjustment payments for targeted access and critical care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period July 1, 1992 through September 30, 1992, shall be 25% of the annual adjustment payments calculated for each eligible hospital, as of June 30, 1992. The Illinois Department shall determine by rule the adjustment payments for targeted access and critical care beginning October 1, 1992.

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

(b) Inpatient payments. For inpatient services provided on or after October 1, 1993, in addition to rates paid for hospital inpatient services pursuant to the Illinois Health Finance Reform Act, as now or hereafter amended, or the

Illinois Department's prospective reimbursement methodology, or any other methodology used by the Illinois Department for inpatient services, the Illinois Department shall make adjustment payments, in an amount calculated pursuant to the methodology described in paragraph (c) of this Section, to hospitals that the Illinois Department determines satisfy any one of the following requirements:

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

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

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

(4) Illinois hospitals that:

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

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services; or

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

(c) Inpatient adjustment payments. The adjustment payments required by paragraph (b) shall be calculated based upon the

hospital's Medicaid inpatient utilization rate as follows:

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

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

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

(4) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $90 plus $2 for each one percent that the

hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (5) of paragraph (b), excluding county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

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

thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month period for which data are available or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate.

(f) Children's hospital inpatient adjustment payments. For children's hospitals, as defined in clause (5) of paragraph (b), the adjustment payments required pursuant to paragraphs (c) and (d) shall be multiplied by 2.0.

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

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

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

(2) "Mean Medicaid inpatient utilization rate" means the total number of Medicaid inpatient days provided by all Illinois Medicaid-participating hospitals divided by the

total number of inpatient days provided by those same hospitals.

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

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

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

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

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

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

(305 ILCS 5/5-5.05)

Sec. 5-5.05. Hospitals; psychiatric services.

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

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

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

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

(3) BroMenn Healthcare, Bloomington, Illinois.

(4) Jackson Park Hospital, Chicago, Illinois.

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

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

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

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

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

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

(11) Rockford Memorial Hospital, Rockford, Illinois.

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

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

(14) Rush-Presbyterian-St. Luke's Medical Center,

Chicago, Illinois.

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

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

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

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

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

(20) Memorial Hospital, Belleville, Illinois.

(21) Swedish Covenant Hospital, Chicago, Illinois.

(22) Trinity Medical Center, Rock Island, Illinois.

(23) St. Elizabeth Hospital, Chicago, Illinois.

(24) Richland Memorial Hospital, Olney, Illinois.

(25) St. Elizabeth's Hospital, Belleville, Illinois.

(26) Samaritan Health System, Clinton, Iowa.

(27) St. John's Hospital, Springfield, Illinois.

(28) St. Mary's Hospital, Centralia, Illinois.

(29) Loretto Hospital, Chicago, Illinois.

(30) Kenneth Hall Regional Hospital, East St. Louis, Illinois.

(31) Hinsdale Hospital, Hinsdale, Illinois.

(32) Pekin Hospital, Pekin, Illinois.

(33) University of Chicago Medical Center, Chicago, Illinois.

(34) St. Anthony's Health Center, Alton, Illinois.

(35) OSF St. Francis Medical Center, Peoria, Illinois.

(36) Memorial Medical Center, Springfield, Illinois.

(37) A hospital with a distinct part unit for psychiatric services that begins operating on or after July 1, 2008.

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

(c) No rules shall be promulgated to implement this Section. For purposes of this Section, "rules" is given the meaning contained in Section 1-70 of the Illinois Administrative Procedure Act.

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

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

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

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

Sec. 5-5.2. Payment.

(a) All nursing facilities that are grouped pursuant to

Section 5-5.1 of this Act shall receive the same rate of payment for similar services.

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

(c) Notwithstanding any other provisions of this Code, ~~beginning July 1, 2012~~ the methodologies for reimbursement of nursing ~~facility~~ services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Resource Utilization Groups (RUGs) has been fully operationalized, which shall take effect for services provided on or after January 1, 2014. ~~State fiscal years 2012 and thereafter. The Department of Healthcare and Family Services shall, effective July 1, 2012, implement an evidence based payment methodology for the reimbursement of nursing facility services. The methodology shall continue to take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Resident Assessment Instrument, adopted and in use by the federal government.~~

(d) A new nursing services reimbursement methodology utilizing RUGs IV 48 grouper model shall be established and may include an Illinois-specific default group, as needed. The new RUGs-based nursing services reimbursement methodology shall be resident-driven, facility-specific, and cost-based. Costs

shall be annually rebased and case mix index quarterly updated. The methodology shall include regional wage adjustors based on the Health Service Areas (HSA) groupings in effect on April 30, 2012. The Department shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study utilizing an index maximization approach.

(e) Notwithstanding any other provision of this Code, the Department shall by rule develop a reimbursement methodology reflective of the intensity of care and services requirements of low need residents in the lowest RUG IV groupers and corresponding regulations.

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

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act, rates effective May 1, 2011 shall be adjusted as follows:

(1) Individual nursing rates for residents classified

in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter ending March 31, 2012 shall be reduced by 10%;

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

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

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

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

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

Sec. 5-5.3. Conditions of Payment - Prospective Rates - Accounting Principles. This amendatory Act establishes certain conditions for the Department of Healthcare and Family Services in instituting rates for the care of recipients of medical assistance in nursing facilities and ICF/DDs. Such conditions shall assure a method under which the payment for nursing facility and ICF/DD services provided to recipients under the Medical Assistance Program shall be on a reasonable cost related basis, which is prospectively determined at least annually by the Department of Public Aid (now Healthcare and

Family Services). The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. There shall be no rate increase during calendar year 1983 and the first six months of calendar year 1984.

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

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

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

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

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

Sec. 5-5.4. Standards of Payment - Department of Healthcare

and Family Services. The Department of Healthcare and Family Services shall develop standards of payment of nursing facility and ICF/DD services in facilities providing such services under this Article which:

(1) Provide for the determination of a facility's payment for nursing facility or ICF/DD services on a prospective basis. The amount of the payment rate for all nursing facilities certified by the Department of Public Health under the ID/DD Community Care Act or the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities, Long Term Care for Under Age 22 facilities, Skilled Nursing facilities, or Intermediate Care facilities under the medical assistance program shall be prospectively established annually on the basis of historical, financial, and statistical data reflecting actual costs from prior years, which shall be applied to the current rate year and updated for inflation, except that the capital cost element for newly constructed facilities shall be based upon projected budgets. The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. No rate increase and no update for inflation shall be provided on or after July 1, 1994 and before January 1, 2014 ~~July 1, 2012~~, unless specifically provided for in this Section. The changes made by Public Act 93-841 extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1998 shall include an increase of 3%. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1998 shall include an increase of 3% plus $1.10 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2006 shall include an increase of 3%. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2009 shall include an increase sufficient to provide a $0.50 per hour wage increase for non-executive staff.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% plus $3.00 per resident-day, as defined by the Department. For facilities licensed by the

Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% and, for services provided on or after October 1, 1999, shall be increased by $4.00 per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, a new payment methodology must be implemented for the nursing component of the rate effective July 1, 2003. The Department of Public Aid (now Healthcare and Family Services) shall develop the new payment methodology using the Minimum Data Set (MDS) as the instrument to collect information concerning nursing home resident condition necessary to compute the rate. The Department shall develop the new payment methodology to meet the unique needs of Illinois

nursing home residents while remaining subject to the appropriations provided by the General Assembly. A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect on July 1, 2003 shall be provided for a period not exceeding 3 years and 184 days after implementation of the new payment methodology as follows:

(A) For a facility that would receive a lower nursing component rate per patient day under the new system than the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be held at the level in effect on the date immediately preceding the date that the Department implements the new payment methodology until a higher nursing component rate of reimbursement is achieved by that facility.

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

(C) Notwithstanding paragraphs (A) and (B), the nursing component rate per patient day for the facility shall be adjusted subject to appropriations provided by the

General Assembly.

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

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

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

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

(iii) For rates taking effect January 1, 2009,

$194,000,000.

(iv) For rates taking effect April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, $416,500,000 or an amount as may be necessary to complete the transition to the MDS methodology for the nursing component of the rate. Increased payments under this item (iv) are not due and payable, however, until (i) the methodologies described in this paragraph are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed by Section 5B-2 of this Code is determined to be a permissible tax under Title XIX of the Social Security Act.

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

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on April 1, 2002 shall include a statewide increase of 2.0%, as defined by the

Department. This increase terminates on July 1, 2002; beginning July 1, 2002 these rates are reduced to the level of the rates in effect on March 31, 2002, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on July 1, 2001 shall be computed using the most recent cost reports on file with the Department of Public Aid no later than April 1, 2000, updated for inflation to January 1, 2001. For rates effective July 1, 2001 only, rates shall be the greater of the rate computed for July 1, 2001 or the rate effective on June 30, 2001.

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

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, if the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68 are approved by the United States Centers for Medicare and Medicaid Services, the rates taking effect on July

1, 2004 shall be 3.0% greater than the rates in effect on June 30, 2004. These rates shall take effect only upon approval and implementation of the payment methodologies required under Section 5A-12.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on January 1, 2005 shall be 3% more than the rates in effect on December 31, 2004.

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

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, or facilities licensed by the Department of Public Health under

the Specialized Mental Health Rehabilitation ~~Facilities~~ Act, a socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The socio-development component of the rate shall be increased by a factor of 2.53 on the first day of the month that begins at least 45 days after January 11, 2008 (the effective date of Public Act 95-707). As of August 1, 2008, the socio-development component rate shall be equal to 6.6% of the facility's nursing component rate as of January 1, 2006, multiplied by a factor of 3.53. For services provided on or after April 1, 2011, or the first day of the month that begins at least 45 days after the effective date of this amendatory Act of the 96th General Assembly, whichever is later, the Illinois Department may by rule adjust these socio-development component rates, and may use different adjustment methodologies for those facilities participating, and those not participating, in the Illinois Department's demonstration program pursuant to the provisions of Title 77, Part 300, Subpart T of the Illinois Administrative Code, but in no case may such rates be diminished below those in effect on August 1, 2008.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or as long-term care facilities for residents under 22 years of age, the rates taking effect on July 1, 2003 shall include a statewide

increase of 4%, as defined by the Department.

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

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

Rates established effective each July 1 shall govern payment for services rendered throughout that fiscal year, except that rates established on July 1, 1996 shall be increased by 6.8% for services provided on or after January 1, 1997. Such rates will be based upon the rates calculated for

the year beginning July 1, 1990, and for subsequent years thereafter until June 30, 2001 shall be based on the facility cost reports for the facility fiscal year ending at any point in time during the previous calendar year, updated to the midpoint of the rate year. The cost report shall be on file with the Department no later than April 1 of the current rate year. Should the cost report not be on file by April 1, the Department shall base the rate on the latest cost report filed by each skilled care facility and intermediate care facility, updated to the midpoint of the current rate year. In determining rates for services rendered on and after July 1, 1985, fixed time shall not be computed at less than zero. The Department shall not make any alterations of regulations which would reduce any component of the Medicaid rate to a level below what that component would have been utilizing in the rate effective on July 1, 1984.

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

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

(4) Shall take into account the actual costs incurred by facilities in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the U.S.

Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

The Department of Healthcare and Family Services shall develop precise standards for payments to reimburse nursing facilities for any utilization of appropriate rehabilitative personnel for the provision of rehabilitative services which is authorized by federal regulations, including reimbursement for services provided by qualified therapists or qualified assistants, and which is in accordance with accepted professional practices. Reimbursement also may be made for utilization of other supportive personnel under appropriate supervision.

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

Act.

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

~~(6)~~ No payment increase under this Section for the MDS methodology, exceptional care residents, or the socio-development component rate established by Public Act 96-1530 of the 96th General Assembly and funded by the assessment imposed under Section 5B-2 of this Code shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under this Section have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under this Section and the waivers granted under 42 CFR 433.68, all increased payments otherwise due under this Section prior to the date of notification shall be due and payable within 90 days of the date federal approval is received.

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

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

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

(305 ILCS 5/5-5.4e)

Sec. 5-5.4e. Nursing facilities; ventilator rates. On and after October 1, 2009, the Department of Healthcare and Family Services shall adopt rules to provide medical assistance reimbursement under this Article for the care of persons on ventilators in skilled nursing facilities licensed under the Nursing Home Care Act and certified to participate under the medical assistance program. Accordingly, necessary amendments to the rules implementing the Minimum Data Set (MDS) payment methodology shall also be made to provide a separate per diem ventilator rate based on days of service. The Department may adopt rules necessary to implement this amendatory Act of the 96th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act, except that the 24-month limitation on the adoption of emergency rules under Section 5-45 and the provisions of Sections 5-115 and 5-125 of that Act do not apply

to rules adopted under this Section. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 96th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

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

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

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

Sec. 5-5.5. Elements of Payment Rate.

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

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

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

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

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

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

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

(1) Reasonable capital cost determined by utilizing incurred interest rate and the current value of the investment, including land, utilizing composite rates, or

by utilizing such other reasonable cost related methods determined by the Department. However, beginning with the rate reimbursement period effective July 1, 1987, the Department shall be prohibited from establishing, including, and implementing any depreciation factor in calculating the capital cost element.

(2) Profit, with the actual amount being produced and accruing to the providers in the form of a return on their total investment, on the basis of their ability to economically and efficiently deliver a type of service. The method of payment may assure the opportunity for a profit, but shall not guarantee or establish a specific amount as a cost.

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

(d) No later than January 1, 2001, the Department of Public Aid shall file with the Joint Committee on Administrative Rules, pursuant to the Illinois Administrative Procedure Act, a proposed rule, or a proposed amendment to an existing rule,

regarding payment for appropriate services, including assessment, care planning, discharge planning, and treatment provided by nursing facilities to residents who have a serious mental illness.

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

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

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

Sec. 5-5.8b. Payment to Campus Facilities. There is hereby established a separate payment category for campus facilities. A "campus facility" is defined as an entity which consists of a long term care facility (or group of facilities if the facilities are on the same contiguous parcel of real estate) which meets all of the following criteria as of May 1, 1987: the entity provides care for both children and adults; residents of the entity reside in three or more separate buildings with congregate and small group living arrangements on a single campus; the entity provides three or more separate licensed levels of care; the entity (or a part of the entity) is enrolled with the Department of Healthcare and Family Services as a provider of long term care services and receives

payments from that Department; the entity (or a part of the entity) receives funding from the Department of Human Services; and the entity (or a part of the entity) holds a current license as a child care institution issued by the Department of Children and Family Services.

The Department of Healthcare and Family Services, the Department of Human Services, and the Department of Children and Family Services shall develop jointly a rate methodology or methodologies for campus facilities. Such methodology or methodologies may establish a single rate to be paid by all the agencies, or a separate rate to be paid by each agency, or separate components to be paid to different parts of the campus facility. All campus facilities shall receive the same rate of payment for similar services. Any methodology developed pursuant to this section shall take into account the actual costs to the facility of providing services to residents, and shall be adequate to reimburse the allowable costs of a campus facility which is economically and efficiently operated. Any methodology shall be established on the basis of historical, financial, and statistical data submitted by campus facilities, and shall take into account the actual costs incurred by campus facilities in providing services, and in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the United States Department of Health and Human Services. Rates may be

established on a prospective or retrospective basis. Any methodology shall provide reimbursement for appropriate payment elements, including the following: standard services, patient services, real estate taxes, and capital costs.

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

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

(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) 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 or to

a resident of a facility licensed under the ID/DD ~~MR/DD~~ Community Care Act, 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 or to a resident of a facility licensed under the ID/DD ~~MR/DD~~ Community Care Act, 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 or brand name, non-narcotic maintenance medication in circumstances where it is cost effective.

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

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

(h-5) On and after July 1, 2012, the Department shall impose utilization controls, including, but not limited to,

prior approval on specialty drugs, oncolytic drugs, drugs for the treatment of HIV or AIDS, immunosuppressant drugs, and biological products in order to maximize savings on these drugs. The Department may adjust payment methodologies for non-pharmacy billed drugs in order to incentivize the selection of lower-cost drugs. For drugs for the treatment of AIDS, the Department shall take into consideration the potential for non-adherence by certain populations, and shall develop protocols with organizations or providers primarily serving those with HIV/AIDS, as long as such measures intend to maintain cost neutrality with other utilization management controls such as prior approval. For hemophilia, the Department shall develop a program of utilization review and control which may include, in the discretion of the Department, prior approvals. The Department may impose special standards on providers that dispense blood factors which shall include, in the discretion of the Department, staff training and education; patient outreach and education; case management; in-home patient assessments; assay management; maintenance of stock; emergency dispensing timeframes; data collection and reporting; dispensing of supplies related to blood factor infusions; cold chain management and packaging practices; care coordination; product recalls; and emergency clinical consultation. The Department may require patients to receive a comprehensive examination annually at an appropriate provider in order to be eligible to continue to receive blood factor.

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

(i) (Blank). ~~The Department shall seek any necessary waiver from the federal government in order to establish a program limiting the pharmacies eligible to dispense specialty drugs and shall issue a Request for Proposals in order to maximize savings on these drugs. The Department shall by rule establish the drugs required to be dispensed in this program.~~

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

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

(l) Any provider enrolled with the Department that bills the Department for outpatient drugs and is eligible to enroll

in the federal Drug Pricing Program under Section 340B of the federal Public Health Services Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under Section 340B of the federal Public Health Services Act may exclude Medicaid from their participation in that program.

(Source: P.A. 96-1269, eff. 7-26-10; 96-1372, eff. 7-29-10; 96-1501, eff. 1-25-11; 97-38, eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11; 97-426, eff. 1-1-12; revised 10-4-11.)

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

Sec. 5-5.17. Separate reimbursement rate. The Illinois Department may by rule establish a separate reimbursement rate to be paid to long term care facilities for adult developmental training services as defined in Section 15.2 of the Mental Health and Developmental Disabilities Administrative Act which are provided to intellectually disabled residents of such facilities who receive aid under this Article. Any such reimbursement shall be based upon cost reports submitted by the providers of such services and shall be paid by the long term care facility to the provider within such time as the Illinois Department shall prescribe by rule, but in no case less than 3 business days after receipt of the reimbursement by such facility from the Illinois Department. The Illinois Department may impose a penalty upon a facility which does not make

payment to the provider of adult developmental training services within the time so prescribed, up to the amount of payment not made to the provider.

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

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

(305 ILCS 5/5-5.20)

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

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

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

(305 ILCS 5/5-5.23)

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

(a) The Department of Healthcare and Family Services, by rule, shall require the screening and assessment of a child prior to any Medicaid-funded admission to an inpatient hospital for psychiatric services to be funded by Medicaid. The screening and assessment shall include a determination of the appropriateness and availability of out-patient support services for necessary treatment. The Department, by rule, shall establish methods and standards of payment for the screening, assessment, and necessary alternative support services.

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

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

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

accordance with Section 5-5e.

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

(305 ILCS 5/5-5.24)

Sec. 5-5.24. Prenatal and perinatal care. The Department of Healthcare and Family Services may provide reimbursement under this Article for all prenatal and perinatal health care services that are provided for the purpose of preventing low-birthweight infants, reducing the need for neonatal intensive care hospital services, and promoting perinatal health. These services may include comprehensive risk assessments for pregnant women, women with infants, and infants, lactation counseling, nutrition counseling, childbirth support, psychosocial counseling, treatment and prevention of periodontal disease, and other support services that have been proven to improve birth outcomes. The Department shall maximize the use of preventive prenatal and perinatal health care services consistent with federal statutes, rules, and regulations. The Department of Public Aid (now Department of Healthcare and Family Services) shall develop a plan for prenatal and perinatal preventive health care and shall present the plan to the General Assembly by January 1, 2004. On or before January 1, 2006 and every 2 years thereafter, the Department shall report to the General Assembly concerning the effectiveness of prenatal and perinatal health care services reimbursed under this Section in preventing low-birthweight

infants and reducing the need for neonatal intensive care hospital services. Each such report shall include an evaluation of how the ratio of expenditures for treating low-birthweight infants compared with the investment in promoting healthy births and infants in local community areas throughout Illinois relates to healthy infant development in those areas.

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

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

(305 ILCS 5/5-5.25)

Sec. 5-5.25. Access to psychiatric mental health services. The General Assembly finds that providing access to psychiatric mental health services in a timely manner will improve the quality of life for persons suffering from mental illness and will contain health care costs by avoiding the need for more costly inpatient hospitalization. The Department of Healthcare and Family Services shall reimburse psychiatrists and federally qualified health centers as defined in Section 1905(l)(2)(B) of the federal Social Security Act for mental health services provided by psychiatrists, as authorized by Illinois law, to recipients via telepsychiatry. The Department, by rule, shall establish (i) criteria for such

services to be reimbursed, including appropriate facilities and equipment to be used at both sites and requirements for a physician or other licensed health care professional to be present at the site where the patient is located, and (ii) a method to reimburse providers for mental health services provided by telepsychiatry.

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

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

(305 ILCS 5/5-5e new)

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

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

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

(2) Cease payment for bed reserves in nursing facilities, specialized mental health rehabilitation

facilities, and, except in the instance of residents who are under 21 years of age, intermediate care facilities for persons with developmental disabilities.

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

(b) After the application of subsection (a), notwithstanding any other provision of this Code to the contrary and to the extent permitted by federal law, on and after July 1, 2012, the rates of reimbursement for services and other payments provided under this Code shall further be reduced as follows:

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

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

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

(4) Rates or payments for hospital services delivered by a Critical Access Hospital, which is an Illinois

hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, Subpart F, shall not be further reduced.

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

(6) Rates or payments for services delivered by long term care facilities licensed under the ID/DD Community Care Act and developmental training services shall not be further reduced.

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

(8) For hospitals not previously described in this subsection, the rates or payments for hospital services shall be further reduced by 3.5%.

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

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

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

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

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

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

(2) does not operate for profit; and

(3) is a disproportionate share hospital, as described in Section 1923 of the federal Social Security Act, as determined by the Department; and

(4) meets one of the following:

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

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

(b) Definitions. As used in this Section:

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

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

the total number of the hospital's inpatient days in that same period.

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

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

(c) For the 15-month period beginning July 1, 2012, a hospital that would have qualified for the rate year beginning October 1, 2011, shall be a Safety-Net Hospital.

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

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

(305 ILCS 5/5-5f new)

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

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

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and physical therapy services; (iii) the Department shall limit podiatry services to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; and (v) the Department shall limit adult dental services to emergencies.

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

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated

potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

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

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

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

(h) The Department shall not pay for hospital admissions when the claim indicates a hospital acquired condition that would cause Medicare to reduce its payment on the claim had the claim been submitted to Medicare, nor shall the Department pay

for hospital admissions where a Medicare identified "never event" occurred.

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

(305 ILCS 5/5-16.7)

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

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

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

(305 ILCS 5/5-16.7a)

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

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

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

(305 ILCS 5/5-16.8)

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

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

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

(305 ILCS 5/5-16.9)

Sec. 5-16.9. Woman's health care provider. The medical assistance program is subject to the provisions of Section 356r of the Illinois Insurance Code. The Illinois Department shall

adopt rules to implement the requirements of Section 356r of the Illinois Insurance Code in the medical assistance program including managed care components.

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

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

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

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

(a) (1) The General Assembly finds:

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

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

(2) To help expand the availability of hospital care for all citizens of this State, it is the policy of the State to implement programs that more equitably distribute

the burden of providing hospital care to Illinois' low-income population and that improve access to health care in Illinois.

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

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

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

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

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

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

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

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

Sec. 5-19. Healthy Kids Program.

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

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

(c) Healthy Kids Examinations. The Illinois Department shall consider any examination of a child eligible for the Healthy Kids services provided by a medical provider meeting

the requirements and complying with the rules and regulations of the Illinois Department to be reimbursed as a Healthy Kids examination.

(d) Medical Screening Examinations.

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

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

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

(B) necessary for enrollment in school; or

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

(D) necessary for placement in a licensed child welfare facility, including a foster home, group home or child care institution; or

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

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

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

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

(I) deemed appropriate by the Illinois Department.

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

(1) Comprehensive Health and Development Assessment including:

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

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

(2) Comprehensive unclothed physical exam;

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

(4) Appropriate laboratory tests including blood lead

levels appropriate for age and risk factors.

(A) Anemia test.

(B) Sickle cell test.

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

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

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

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

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

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

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

(g) Notice of Healthy Kids Services.

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

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

the constituents of each of the Program and assist individuals, as feasible, with applying for the Program, (ii) using the media for public service announcements and advertisements of the Program, and (iii) developing posters advertising the Program for display in hospital and clinic waiting rooms.

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

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

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

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

(C) at least 20 days before the date of any periodic health, vision, hearing, and dental examination for any child eligible for Healthy Kids services. Notice given under this subparagraph (C) must state that a screening examination is due under the periodicity schedules and must advise the eligible child and his or her family that the Illinois

Department will provide assistance in scheduling an appointment and arranging medical transportation.

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

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

(Source: P.A. 87-630; 87-895.)

(305 ILCS 5/5-24)

(Section scheduled to be repealed on January 1, 2014)

Sec. 5-24. Disease management programs and services for chronic conditions; pilot project.

(a) In this Section, "disease management programs and services" means services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications, using cost-effective, evidence-based practice guidelines and patient self-management

strategies. Disease management programs and services include all of the following:

(1) A population identification process.

(2) Evidence-based or consensus-based clinical practice guidelines, risk identification, and matching of interventions with clinical need.

(3) Patient self-management and disease education.

(4) Process and outcomes measurement, evaluation, management, and reporting.

(b) Subject to appropriations, the Department of Healthcare and Family Services may undertake a pilot project to study patient outcomes, for patients with chronic diseases or patients at risk of low birth weight or premature birth, associated with the use of disease management programs and services for chronic condition management. "Chronic diseases" include, but are not limited to, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Low birth weight and premature birth include all medical and other conditions that lead to poor birth outcomes or problematic pregnancies.

(c) The disease management programs and services pilot project shall examine whether chronic disease management programs and services for patients with specific chronic conditions do any or all of the following:

(1) Improve the patient's overall health in a more expeditious manner.

(2) Lower costs in other aspects of the medical assistance program, such as hospital admissions, days in skilled nursing homes, emergency room visits, or more frequent physician office visits.

(d) In carrying out the pilot project, the Department of Healthcare and Family Services shall examine all relevant scientific literature and shall consult with health care practitioners including, but not limited to, physicians, surgeons, registered pharmacists, and registered nurses.

(e) The Department of Healthcare and Family Services shall consult with medical experts, disease advocacy groups, and academic institutions to develop criteria to be used in selecting a vendor for the pilot project.

(f) The Department of Healthcare and Family Services may adopt rules to implement this Section.

(g) This Section is repealed 10 years after the effective date of this amendatory Act of the 93rd General Assembly.

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

(Source: P.A. 95-331, eff. 8-21-07; 96-799, eff. 10-28-09.)

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

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

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

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

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

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

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

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

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

(4) The Department shall examine whether chronic mental health management programs and services for recipients with specific chronic mental health conditions

do any or all of the following:

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

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

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

(f) A hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as set forth in Section 5-30 of this Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of this Code for which it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital no later that 60 days after the effective date of this amendatory Act of the 97th General assembly or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care program. For purposes of this subsection, "Coordinated Care Participating Hospital" means a hospital that meets one of the following

criteria:

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

(2) The hospital has not been offered a contract by a care coordination plan that pays at least as much as the Department would pay, on a fee-for-service-basis, not including disproportionate share hospital adjustment payments or any other supplemental adjustment or add-on payment to the base fee-for-service rate.

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

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

Sec. 5A-1. Definitions. As used in this Article, unless the context requires otherwise:

~~"Adjusted gross hospital revenue" shall be determined separately for inpatient and outpatient services for each hospital conducted, operated or maintained by a hospital provider, and means the hospital provider's total gross revenues less: (i) gross revenue attributable to non-hospital based services including home dialysis services, durable medical equipment, ambulance services, outpatient clinics and any other non-hospital based services as determined by the Illinois Department by rule; and (ii) gross revenues attributable to the routine services provided to persons receiving skilled or intermediate long term care services~~

~~within the meaning of Title XVIII or XIX of the Social Security Act; and (iii) Medicare gross revenue (excluding the Medicare gross revenue attributable to clauses (i) and (ii) of this paragraph and the Medicare gross revenue attributable to the routine services provided to patients in a psychiatric hospital, a rehabilitation hospital, a distinct part psychiatric unit, a distinct part rehabilitation unit, or swing beds). Adjusted gross hospital revenue shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2004, without regard to any subsequent adjustments or changes to such data. If a hospital's 2003 Medicare cost report is not contained in the Healthcare Cost Report Information System, the hospital provider shall furnish such cost report or the data necessary to determine its adjusted gross hospital revenue as required by rule by the Illinois Department.~~

"Fund" means the Hospital Provider Fund.

"Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

"Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid

provider. For purposes of this paragraph, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

"Medicare bed days" means, for each hospital, the sum of the number of days that each bed was occupied by a patient who was covered by Title XVIII of the Social Security Act, excluding days attributable to the routine services provided to persons receiving skilled or intermediate long term care services. Medicare bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding days attributable to the routine services provided to persons receiving skilled or intermediate long term care services. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

~~"Proration factor" means a fraction, the numerator of which is 53 and the denominator of which is 365.~~

(Source: P.A. 94-242, eff. 7-18-05; 95-859, eff. 8-19-08.)

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

(Section scheduled to be repealed on July 1, 2014)

Sec. 5A-2. Assessment.

(a) ~~Subject to Sections 5A-3 and 5A-10, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to the hospital's occupied bed days multiplied by $84.19 multiplied by the proration factor for State fiscal year 2004 and the hospital's occupied bed days multiplied by $84.19 for State fiscal year 2005.~~

~~For State fiscal years 2004 and 2005, the Department of Healthcare and Family Services shall use the number of occupied bed days as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health to calculate the hospital's annual assessment. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals or if there are data errors in the reported sum of a hospital's occupied bed days as determined by the Department of Healthcare and Family Services (formerly Department of Public Aid), then the Department of Healthcare and Family Services may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department of Healthcare and Family Services or its duly authorized agents and employees.~~

~~Subject to Sections 5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007, and 2008,~~

~~in an amount equal to 2.5835% of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835% of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Illinois Department may obtain the hospital provider's adjusted gross hospital revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.~~

Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2014 and July 1, 2014 through December 31, 2014, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days.

For State fiscal years 2009 through 2014 and after, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may

obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

(b) (Blank).

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized~~, during this 94th General Assembly,~~ to adopt rules to reduce the rate of any annual assessment imposed under this Section, as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a

timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

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

Sec. 5A-3. Exemptions.

(a) (Blank).

(a-5) A hospital provider that is a county, township, municipality, hospital district, or any other local governmental unit is exempt from the assessment imposed by Section 5A-2.

(b) A hospital provider that is a State agency or ~~,~~ a State university~~, or a county with a population of 3,000,000 or more~~ is exempt from the assessment imposed by Section 5A-2.

(b-2) (Blank). ~~A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality,~~

~~hospital district, or any other local governmental unit is exempt from the assessment imposed by Section 5A-2.~~

(b-5) (Blank).

(b-10) (Blank). ~~For State fiscal years 2004 through 2014, a hospital provider, described in Section 1903(w)(3)(F) of the Social Security Act, whose hospital does not charge for its services is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.~~

(b-15) (Blank). ~~For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.~~

(b-20) (Blank). ~~For State fiscal years 2004 and 2005, a hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.~~

(b-25) (Blank). ~~For State fiscal years 2004 and 2005, a hospital provider whose hospital (i) is not a psychiatric~~

~~hospital, rehabilitation hospital, or children's hospital and (ii) has an average length of inpatient stay greater than 25 days is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.~~

(c) (Blank).

(Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

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

Sec. 5A-4. Payment of assessment; penalty.

(a) The ~~The annual assessment imposed by Section 5A-2 for State fiscal year 2004 shall be due and payable on June 18 of the year. The assessment imposed by Section 5A-2 for State fiscal year 2005 shall be due and payable in quarterly installments, each equalling one fourth of the assessment for the year, on July 19, October 19, January 18, and April 19 of the year. The assessment imposed by Section 5A-2 for State fiscal years 2006 through 2008 shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year, on the fourteenth State business day of September, December, March, and May. Except as provided in subsection (a-5) of this Section, the~~ assessment imposed by Section 5A-2 for State fiscal year 2009 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for

the year, on the fourteenth State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after the Comptroller has issued the payments required under this Article. ~~: (i) the Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waiver under 42 CFR 433.68 for the assessment imposed by Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, and the waiver granted under 42 CFR 433.68, all installments otherwise due under Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.1 or Section 5A-12.2, whichever is applicable for that fiscal year.~~

(a-5) The Illinois Department may, for the purpose of

maximizing federal revenue, accelerate the schedule upon which assessment installments are due and payable by hospitals with a payment ratio greater than or equal to one. Such acceleration of due dates for payment of the assessment may be made only in conjunction with a corresponding acceleration in access payments identified in Section 5A-12.2 to the same hospitals. For the purposes of this subsection (a-5), a hospital's payment ratio is defined as the quotient obtained by dividing the total payments for the State fiscal year, as authorized under Section 5A-12.2, by the total assessment for the State fiscal year imposed under Section 5A-2.

(b) The Illinois Department is authorized to establish delayed payment schedules for hospital providers that are unable to make installment payments when due under this Section due to financial difficulties, as determined by the Illinois Department.

(c) If a hospital provider fails to pay the full amount of an installment when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5A-2 a penalty assessment equal to the lesser of (i) 5% of the amount of the installment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter or (ii) 100% of the installment amount not paid on or before the due date. For purposes of this subsection, payments will be

credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

(d) Any assessment amount that is due and payable to the Illinois Department more frequently than once per calendar quarter shall be remitted to the Illinois Department by the hospital provider by means of electronic funds transfer. The Illinois Department may provide for remittance by other means if (i) the amount due is less than $10,000 or (ii) electronic funds transfer is unavailable for this purpose.

(Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08; 96-821, eff. 11-20-09.)

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

Sec. 5A-5. Notice; penalty; maintenance of records.

(a) The Illinois Department ~~of Healthcare and Family Services~~ shall send a notice of assessment to every hospital provider subject to assessment under this Article. The notice of assessment shall notify the hospital of its assessment and shall be sent after receipt by the Department of notification from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services that the payment methodologies required under this Article ~~Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year~~, and, if necessary, the waiver granted under 42 CFR 433.68 have been approved. The notice shall be on

a form prepared by the Illinois Department and shall state the following:

(1) The name of the hospital provider.

(2) The address of the hospital provider's principal place of business from which the provider engages in the occupation of hospital provider in this State, and the name and address of each hospital operated, conducted, or maintained by the provider in this State.

(3) The occupied bed days, occupied bed days less Medicare days, or adjusted gross hospital revenue of the hospital provider (whichever is applicable), the amount of assessment imposed under Section 5A-2 for the State fiscal year for which the notice is sent, and the amount of each installment to be paid during the State fiscal year.

(4) (Blank).

(5) Other reasonable information as determined by the Illinois Department.

(b) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, the provider shall pay the assessment for each hospital separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to conduct, operate, or maintain a hospital in respect of which the person is subject to assessment under this Article as a hospital provider, the assessment for the State fiscal year in which the cessation

occurs shall be adjusted by multiplying the assessment computed under Section 5A-2 by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate, or maintain a hospital, the person shall pay the assessment for the year as so adjusted (to the extent not previously paid).

(d) Notwithstanding any other provision in this Article, a provider who commences conducting, operating, or maintaining a hospital, upon notice by the Illinois Department, shall pay the assessment computed under Section 5A-2 and subsection (e) in installments on the due dates stated in the notice and on the regular installment due dates for the State fiscal year occurring after the due dates of the initial notice.

(e) ~~Notwithstanding any other provision in this Article, for State fiscal years 2004 and 2005, in the case of a hospital provider that did not conduct, operate, or maintain a hospital throughout calendar year 2001, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for State fiscal years 2006 through 2008, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2003, the assessment for that State fiscal year shall be computed on the basis of hypothetical adjusted gross hospital revenue for the hospital's first full~~

~~fiscal year as determined by the Illinois Department (which may be based on annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior provider of the same hospital during the year).~~ Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2012 ~~2014~~, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department.

(e-5) Notwithstanding any other provision in this Article, for State fiscal year 2013 and each subsequent State fiscal year, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department.

(f) Every hospital provider subject to assessment under this Article shall keep sufficient records to permit the determination of adjusted gross hospital revenue for the hospital's fiscal year. All such records shall be kept in the English language and shall, at all times during regular business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

(g) The Illinois Department may, by rule, provide a hospital provider a reasonable opportunity to request a clarification or correction of any clerical or computational errors contained in the calculation of its assessment, but such corrections shall not extend to updating the cost report information used to calculate the assessment.

(h) (Blank).

(Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

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

Sec. 5A-6. Disposition of proceeds. The Illinois Department shall deposit ~~pay~~ all moneys received from hospital providers under this Article into the Hospital Provider Fund. Upon certification by the Illinois Department to the State Comptroller of its intent to withhold payments from a provider pursuant to ~~under~~ Section 5A-7(b), the State Comptroller shall draw a warrant on the treasury or other fund held by the State Treasurer, as appropriate. The warrant shall state the amount for which the provider is entitled to a warrant, the amount of the deduction, and the reason therefor and shall direct the State Treasurer to pay the balance to the provider, all in accordance with Section 10.05 of the State Comptroller Act. The warrant also shall direct the State Treasurer to transfer the amount of the deduction so ordered from the treasury or other fund into the Hospital Provider Fund.

(Source: P.A. 87-861.)

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

Sec. 5A-8. Hospital Provider Fund.

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

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

(1) For making payments to hospitals as required under ~~Articles V, V-A, VI, and XIV of~~ this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act. ~~Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.~~

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

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing ~~the~~ activities under ~~authorized by~~ this Code, the Children's

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

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

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

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

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

(7) For making transfers not exceeding the following amounts, in each State fiscal year during which an assessment is imposed pursuant to Section 5A-2, to the following designated funds:

Health and Human Services Medicaid Trust Fund $20,000,000
Long-Term Care Provider Fund $30,000,000
General Revenue Fund ..... $80,000,000.

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4. ~~For State fiscal years 2004 and 2005 for making transfers to the Health and Human Services Medicaid Trust Fund, including 20% of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. For State fiscal year 2006 for making transfers to the Health and Human Services Medicaid Trust Fund of up to $130,000,000 per year of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.~~

(7.5) (Blank). ~~For State fiscal year 2007 for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:~~

~~Health and Human Services~~

~~Medicaid Trust Fund ..... $20,000,000~~

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

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

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

(7.8) (Blank). ~~For State fiscal year 2008, for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:~~

~~Health and Human Services~~

~~Medicaid Trust Fund ..... $40,000,000~~

~~Long Term Care Provider Fund ..... $60,000,000~~

~~General Revenue Fund ..... $160,000,000.~~

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

(7.9) (Blank). ~~For State fiscal years 2009 through 2014, for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in~~

~~that State fiscal year:~~

~~Health and Human Services~~

~~Medicaid Trust Fund ..... $20,000,000~~

~~Long Term Care Provider Fund ..... $30,000,000~~

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

~~Except as provided under this paragraph, transfers under this paragraph shall be made within 7 business days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4. For State fiscal year 2009, transfers to the General Revenue Fund under this paragraph shall be made on or before June 30, 2009, as sufficient funds become available in the Hospital Provider Fund to both make the transfers and continue hospital payments.~~

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

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

(c) The Fund shall consist of the following:

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

(2) All federal matching funds received by the Illinois

Department as a result of expenditures made by the Illinois Department that are attributable to moneys deposited in the Fund.

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

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

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

(d) (Blank).

(Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3, eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09; 96-1530, eff. 2-16-11.)

(305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

Sec. 5A-10. Applicability.

(a) The assessment imposed by Section 5A-2 shall ~~not take effect or shall~~ cease to be imposed and the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) The payments to hospitals required under this Article are not eligible for federal matching funds under Title XIX or XXI of the Social Security Act ~~The sum of the appropriations for State fiscal years 2004 and 2005 from the General Revenue Fund for hospital payments under the~~

~~medical assistance program is less than $4,500,000,000 or the appropriation for each of State fiscal years 2006, 2007 and 2008 from the General Revenue Fund for hospital payments under the medical assistance program is less than $2,500,000,000 increased annually to reflect any increase in the number of recipients, or the annual appropriation for State fiscal years 2009, 2010, 2011, 2013, and 2014, from the General Revenue Fund combined with the Hospital Provider Fund as authorized in Section 5A-8 for hospital payments under the medical assistance program, is less than the amount appropriated for State fiscal year 2009, adjusted annually to reflect any change in the number of recipients, excluding State fiscal year 2009 supplemental appropriations made necessary by the enactment of the American Recovery and Reinvestment Act of 2009~~; or

~~(2) For State fiscal years prior to State fiscal year 2009, the Department of Healthcare and Family Services (formerly Department of Public Aid) makes changes in its rules that reduce the hospital inpatient or outpatient payment rates, including adjustment payment rates, in effect on October 1, 2004, except for hospitals described in subsection (b) of Section 5A-3 and except for changes in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, so long as those changes do not reduce aggregate expenditures below the amount expended in State fiscal year 2005 for such~~

~~services; or~~

(2) ~~(2.1)~~ For State fiscal years 2009 through 2014 and July 1, 2014 through December 31, 2014, the Department of Healthcare and Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008 except for:

(A) any changes for hospitals described in subsection (b) of Section 5A-3; or

(B) any rates for payments made under this Article V-A; or

(C) any changes proposed in State plan amendment transmittal numbers 08-01, 08-02, 08-04, 08-06, and 08-07; ~~or~~

(D) in relation to any admissions on or after January 1, 2011, a modification in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, for hospitals reimbursed under the diagnosis-related grouping methodology in effect on January 1, 2011; provided that the Department shall be limited to one such modification during the 36-month period after the effective date of this amendatory Act of the 96th General Assembly; or

(E) any changes affecting hospitals authorized by this amendatory Act of the 97th General Assembly.

~~(3) The payments to hospitals required under Section 5A-12 or Section 5A-12.2 are changed or are not eligible for federal matching funds under Title XIX or XXI of the Social Security Act.~~

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed and the Department's obligation to make payments shall immediately cease if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund derived from assessments imposed prior thereto shall be disbursed in accordance with Section 5A-8 to the extent federal financial participation is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72, eff. 7-1-11; 97-74, eff. 6-30-11.)

(305 ILCS 5/5A-12.2)

(Section scheduled to be repealed on July 1, 2014)

Sec. 5A-12.2. Hospital access payments on or after July 1, 2008.

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2008, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as

set forth in this Section. These payments shall be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act.

(a-5) The Illinois Department may, when practicable, accelerate the schedule upon which payments authorized under this Section are made.

(b) Across-the-board inpatient adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital an amount equal to 40% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay to each freestanding Illinois specialty care hospital as defined in 89 Ill. Adm.

Code 149.50(c)(1), (2), or (4) an amount equal to 60% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay to each freestanding Illinois rehabilitation or psychiatric hospital an amount equal to $1,000 per Medicaid inpatient day multiplied by the increase in the hospital's Medicaid inpatient utilization ratio (determined using the positive percentage change from the rate year 2005 Medicaid inpatient utilization ratio to the rate year 2007 Medicaid inpatient utilization ratio, as calculated by the Department for the disproportionate share determination).

(4) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois children's hospital an amount equal to 20% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005 and an additional amount equal to 20% of the base inpatient payments paid to the hospital for psychiatric services provided in State fiscal year 2005.

(5) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois hospital eligible for a pediatric inpatient adjustment payment under 89 Ill. Adm. Code 148.298, as in effect for State fiscal year 2007, a supplemental pediatric inpatient

adjustment payment equal to:

(i) For freestanding children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5 multiplied by the hospital's pediatric inpatient adjustment payment required under 89 Ill. Adm. Code 148.298, as in effect for State fiscal year 2008.

(ii) For hospitals other than freestanding children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(B), 1.0 multiplied by the hospital's pediatric inpatient adjustment payment required under 89 Ill. Adm. Code 148.298, as in effect for State fiscal year 2008.

(c) Outpatient adjustment.

(1) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois hospital an amount equal to 2.2 multiplied by the hospital's ambulatory procedure listing payments for categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code 148.140(b), for State fiscal year 2005.

(2) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding psychiatric hospital an amount equal to 3.25 multiplied by the hospital's ambulatory procedure listing payments for category 5b, as defined in 89 Ill. Adm. Code 148.140(b)(1)(E), for State fiscal year 2005.

(d) Medicaid high volume adjustment. In addition to rates

paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital that provided more than 20,500 Medicaid inpatient days of care in State fiscal year 2005 amounts as follows:

(1) For hospitals with a case mix index equal to or greater than the 85th percentile of hospital case mix indices, $350 for each Medicaid inpatient day of care provided during that period; and

(2) For hospitals with a case mix index less than the 85th percentile of hospital case mix indices, $100 for each Medicaid inpatient day of care provided during that period.

(e) Capital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% (as calculated by the Department for the rate year 2007 disproportionate share determination) amounts as follows:

(1) For each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% and less than 36.94% and whose capital cost is less than the 60th percentile of the capital costs of all Illinois hospitals, the amount of such payment shall equal the hospital's Medicaid inpatient days multiplied by the difference between the capital costs at the 60th percentile of the capital costs of all Illinois hospitals and the hospital's capital costs.

(2) For each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 36.94% and whose capital cost is less than the 75th percentile of the capital costs of all Illinois hospitals, the amount of such payment shall equal the hospital's Medicaid inpatient days multiplied by the difference between the capital costs at the 75th percentile of the capital costs of all Illinois hospitals and the hospital's capital costs.

(f) Obstetrical care adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay $1,500 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois rural hospital that had a Medicaid obstetrical percentage (Medicaid obstetrical days divided by Medicaid inpatient days) greater than 15% for State fiscal year 2005.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay $1,350 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level III perinatal center as of December 31, 2006, and that had a case mix index equal to or greater than the 45th percentile of the case mix indices for all level III perinatal centers.

(3) In addition to rates paid for inpatient hospital

services, the Department shall pay $900 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level II or II+ perinatal center as of December 31, 2006, and that had a case mix index equal to or greater than the 35th percentile of the case mix indices for all level II and II+ perinatal centers.

(g) Trauma adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay each Illinois general acute care hospital designated as a trauma center as of July 1, 2007, a payment equal to 3.75 multiplied by the hospital's State fiscal year 2005 Medicaid capital payments.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay $400 for each Medicaid acute inpatient day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level II trauma center, as defined in 89 Ill. Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1, 2007.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay $235 for each Illinois Medicaid acute inpatient day of care provided in State fiscal year 2005 by each level I pediatric trauma center located outside of Illinois that had more than 8,000

Illinois Medicaid inpatient days in State fiscal year 2005.

(h) Supplemental tertiary care adjustment. In addition to rates paid for inpatient services, the Department shall pay to each Illinois hospital eligible for tertiary care adjustment payments under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007, a supplemental tertiary care adjustment payment equal to the tertiary care adjustment payment required under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007.

(i) Crossover adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois general acute care hospital that had a ratio of crossover days to total inpatient days for medical assistance programs administered by the Department (utilizing information from 2005 paid claims) greater than 50%, and a case mix index greater than the 65th percentile of case mix indices for all Illinois hospitals, a rate of $1,125 for each Medicaid inpatient day including crossover days.

(j) Magnet hospital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital and each Illinois freestanding children's hospital that, as of February 1, 2008, was recognized as a Magnet hospital by the American Nurses Credentialing Center and that had a case mix index greater than the 75th percentile of case mix indices for all Illinois hospitals amounts as follows:

(1) For hospitals located in a county whose eligibility growth factor is greater than the mean, $450 multiplied by the eligibility growth factor for the county in which the hospital is located for each Medicaid inpatient day of care provided by the hospital during State fiscal year 2005.

(2) For hospitals located in a county whose eligibility growth factor is less than or equal to the mean, $225 multiplied by the eligibility growth factor for the county in which the hospital is located for each Medicaid inpatient day of care provided by the hospital during State fiscal year 2005.

For purposes of this subsection, "eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

(k) For purposes of this Section, a hospital that is enrolled to provide Medicaid services during State fiscal year 2005 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this Section.

(l) For purposes of this Section, the terms "Medicaid days", "ambulatory procedure listing services", and "ambulatory procedure listing payments" do not include any days, charges, or services for which Medicare or a managed care organization reimbursed on a capitated basis was liable for payment, except where explicitly stated otherwise in this

Section.

(m) For purposes of this Section, in determining the percentile ranking of an Illinois hospital's case mix index or capital costs, hospitals described in subsection (b) of Section 5A-3 shall be excluded from the ranking.

(n) Definitions. Unless the context requires otherwise or unless provided otherwise in this Section, the terms used in this Section for qualifying criteria and payment calculations shall have the same meanings as those terms have been given in the Illinois Department's administrative rules as in effect on March 1, 2008. Other terms shall be defined by the Illinois Department by rule.

As used in this Section, unless the context requires otherwise:

"Base inpatient payments" means, for a given hospital, the sum of base payments for inpatient services made on a per diem or per admission (DRG) basis, excluding those portions of per admission payments that are classified as capital payments. Disproportionate share hospital adjustment payments, Medicaid Percentage Adjustments, Medicaid High Volume Adjustments, and outlier payments, as defined by rule by the Department as of January 1, 2008, are not base payments.

"Capital costs" means, for a given hospital, the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31,

2006, divided by the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies (DRI) hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department may obtain the data necessary to compute the hospital's capital costs from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

"Case mix index" means, for a given hospital, the sum of the DRG relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, divided by the total number of general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

"Medicaid inpatient day" means, for a given hospital, the sum of days of inpatient hospital days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare

crossover days), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2005 that was adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical day" means, for a given hospital, the sum of days of inpatient hospital days grouped by the Department to DRGs of 370 through 375 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2005 that was adjudicated by the Department through March 23, 2007.

"Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services, as described in 89 Ill. Adm. Code 148.140(b), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in State fiscal year 2005 that were adjudicated by the Department through March 23, 2007.

(o) The Department may adjust payments made under this Section 5A-12.2 ~~12.2~~ to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.

(p) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules that change the hospital access improvement payments specified in this Section, but only to the extent necessary to conform to any federally approved amendment to the Title XIX State plan. Any such rules shall be adopted by the Department as authorized by Section 5-50 of the Illinois Administrative Procedure Act. Notwithstanding any other provision of law, any changes implemented as a result of this subsection (p) shall be given retroactive effect so that they shall be deemed to have taken effect as of the effective date of this Section.

(q) (Blank). ~~For State fiscal years 2012 and 2013, the Department may make recommendations to the General Assembly regarding the use of more recent data for purposes of calculating the assessment authorized under Section 5A-2 and the payments authorized under this Section 5A-12.2.~~

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

(Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09.)

(305 ILCS 5/5A-14)

Sec. 5A-14. Repeal of assessments and disbursements.

(a) Section 5A-2 is repealed on January 1, 2015 ~~July 1,~~

~~2014~~.

(b) Section 5A-12 is repealed on July 1, 2005.

(c) Section 5A-12.1 is repealed on July 1, 2008.

(d) Section 5A-12.2 is repealed on January 1, 2015 ~~July 1, 2014~~.

(e) Section 5A-12.3 is repealed on July 1, 2011.

(Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09; 96-1530, eff. 2-16-11.)

(305 ILCS 5/5A-15 new)

Sec. 5A-15. Protection of federal revenue.

(a) If the federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under this Article is exceeded then:

(1) the payments under this Article that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the applicable federal upper payment limit; and

(2) any assessment rate imposed under this Article shall be reduced such that the aggregate assessment is reduced by the same percentage reduction applied in paragraph (1); and

(3) any transfers from the Hospital Provider Fund under Section 5A-8 shall be reduced by the same percentage reduction applied in paragraph (1).

(b) Any payment reductions made under the authority granted

in this Section are exempt from the requirements and actions under Section 5A-10.

(305 ILCS 5/6-11) (from Ch. 23, par. 6-11)

Sec. 6-11. ~~State funded~~ General Assistance.

(a) Effective July 1, 1992, all State funded General Assistance and related medical benefits shall be governed by this Section, provided that, notwithstanding any other provisions of this Code to the contrary, on and after July 1, 2012, the State shall not fund the programs outlined in this Section. Other parts of this Code or other laws related to General Assistance shall remain in effect to the extent they do not conflict with the provisions of this Section. If any other part of this Code or other laws of this State conflict with the provisions of this Section, the provisions of this Section shall control.

(b) ~~State funded~~ General Assistance may ~~shall~~ consist of 2 separate programs. One program shall be for adults with no children and shall be known as ~~State~~ Transitional Assistance. The other program may ~~shall~~ be for families with children and for pregnant women and shall be known as ~~State~~ Family and Children Assistance.

(c) (1) To be eligible for ~~State~~ Transitional Assistance on or after July 1, 1992, an individual must be ineligible for assistance under any other Article of this Code, must be determined chronically needy, and must be one of the following:

(A) age 18 or over or

(B) married and living with a spouse, regardless of age.

(2) The ~~Illinois Department or the~~ local governmental unit shall determine whether individuals are chronically needy as follows:

(A) Individuals who have applied for Supplemental Security Income (SSI) and are awaiting a decision on eligibility for SSI who are determined disabled by the Illinois Department using the SSI standard shall be considered chronically needy, except that individuals whose disability is based solely on substance addictions (drug abuse and alcoholism) and whose disability would cease were their addictions to end shall be eligible only for medical assistance and shall not be eligible for cash assistance under the ~~State~~ Transitional Assistance program.

(B) (Blank). ~~If an individual has been denied SSI due to a finding of "not disabled" (either at the Administrative Law Judge level or above, or at a lower level if that determination was not appealed), the Illinois Department shall adopt that finding and the individual shall not be eligible for State Transitional Assistance or any related medical benefits. Such an individual may not be determined disabled by the Illinois Department for a period of 12 months, unless the individual shows that there has~~

~~been a substantial change in his or her medical condition or that there has been a substantial change in other factors, such as age or work experience, that might change the determination of disability.~~

(C) The unit of local government ~~Illinois Department, by rule,~~ may specify other categories of individuals as chronically needy; nothing in this Section, however, shall be deemed to require the inclusion of any specific category other than as specified in paragraph ~~paragraphs~~ (A) ~~and (B)~~.

(3) For individuals in ~~State~~ Transitional Assistance, medical assistance may ~~shall~~ be provided by the unit of local government in an amount and nature determined by the unit of local government. Nothing ~~Department of Healthcare and Family Services by rule. The amount and nature of medical assistance provided need not be the same as that provided under paragraph (4) of subsection (d) of this Section, and nothing~~ in this paragraph (3) shall be construed to require the coverage of any particular medical service. In addition, the amount and nature of medical assistance provided may be different for different categories of individuals determined chronically needy.

(4) (Blank). ~~The Illinois Department shall determine, by rule, those assistance recipients under Article VI who shall be subject to employment, training, or education programs including Earnfare, the content of those programs, and the penalties for failure to cooperate in those programs.~~

(5) (Blank). ~~The Illinois Department shall, by rule, establish further eligibility requirements, including but not limited to residence, need, and the level of payments.~~

(d) (1) To be eligible for ~~State~~ Family and Children Assistance, a family unit must be ineligible for assistance under any other Article of this Code and must contain a child who is:

(A) under age 18 or

(B) age 18 and a full-time student in a secondary school or the equivalent level of vocational or technical training, and who may reasonably be expected to complete the program before reaching age 19.

Those children shall be eligible for ~~State~~ Family and Children Assistance.

(2) The natural or adoptive parents of the child living in the same household may be eligible for ~~State~~ Family and Children Assistance.

(3) A pregnant woman whose pregnancy has been verified shall be eligible for income maintenance assistance under the ~~State~~ Family and Children Assistance program.

(4) The amount and nature of medical assistance provided under the ~~State~~ Family and Children Assistance program shall be determined by the unit of local government ~~Department of Healthcare and Family Services by rule~~. The amount and nature of medical assistance provided need not be the same as that provided under paragraph (3) of subsection (c) of this Section,

and nothing in this paragraph (4) shall be construed to require the coverage of any particular medical service.

(5) (Blank). ~~The Illinois Department shall, by rule, establish further eligibility requirements, including but not limited to residence, need, and the level of payments.~~

(e) A local governmental unit that chooses to participate in a General Assistance program under this Section shall provide funding in accordance with Section 12-21.13 of this Act. Local governmental funds used to qualify for State funding may only be expended for clients eligible for assistance under this Section 6-11 and related administrative expenses.

(f) (Blank). ~~In order to qualify for State funding under this Section, a local governmental unit shall be subject to the supervision and the rules and regulations of the Illinois Department.~~

(g) (Blank). ~~Notwithstanding any other provision in this Code, the Illinois Department is authorized to reduce payment levels used to determine cash grants provided to recipients of State Transitional Assistance at any time within a Fiscal Year in order to ensure that cash benefits for State Transitional Assistance do not exceed the amounts appropriated for those cash benefits. Changes in payment levels may be accomplished by emergency rule under Section 5-45 of the Illinois Administrative Procedure Act, except that the limitation on the number of emergency rules that may be adopted in a 24 month period shall not apply and the provisions of Sections 5-115 and~~

~~5-125 of the Illinois Administrative Procedure Act shall not apply. This provision shall also be applicable to any reduction in payment levels made upon implementation of this amendatory Act of 1995.~~

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

(305 ILCS 5/11-5.2 new)

Sec. 11-5.2. Income, Residency, and Identity Verification System.

(a) The Department shall ensure that its proposed integrated eligibility system shall include the computerized functions of income, residency, and identity eligibility verification to verify eligibility, eliminate duplication of medical assistance, and deter fraud. Until the integrated eligibility system is operational, the Department may enter into a contract with the vendor selected pursuant to Section 11-5.3 as necessary to obtain the electronic data matching described in this Section. This contract shall be exempt from the Illinois Procurement Code pursuant to subsection (h) of Section 1-10 of that Code.

(b) Prior to awarding medical assistance at application under Article V of this Code, the Department shall, to the extent such databases are available to the Department, conduct data matches using the name, date of birth, address, and Social Security Number of each applicant or recipient or responsible relative of an applicant or recipient against the following:

(1) Income tax information.

(2) Employer reports of income and unemployment insurance payment information maintained by the Department of Employment Security.

(3) Earned and unearned income, citizenship and death, and other relevant information maintained by the Social Security Administration.

(4) Immigration status information maintained by the United States Citizenship and Immigration Services.

(5) Wage reporting and similar information maintained by states contiguous to this State.

(6) Employment information maintained by the Department of Employment Security in its New Hire Directory database.

(7) Employment information maintained by the United States Department of Health and Human Services in its National Directory of New Hires database.

(8) Veterans' benefits information maintained by the United States Department of Health and Human Services, in coordination with the Department of Health and Human Services and the Department of Veterans' Affairs, in the federal Public Assistance Reporting Information System (PARIS) database.

(9) Residency information maintained by the Illinois Secretary of State.

(10) A database which is substantially similar to or a

successor of a database described in this Section that contains information relevant for verifying eligibility for medical assistance.

(d) If a discrepancy results between information provided by an applicant, recipient, or responsible relative and information contained in one or more of the databases or information tools listed under subsection (b) or (c) of this Section or subsection (c) of Section 11-5.3 and that discrepancy calls into question the accuracy of information relevant to a condition of eligibility provided by the applicant, recipient, or responsible relative, the Department or its contractor shall review the applicant's or recipient's case using the following procedures:

(1) If the information discovered under subsection (c) of this Section or subsection (c) of Section 11-5.3 does not result in the Department finding the applicant or recipient ineligible for assistance under Article V of this Code, the Department shall finalize the determination or redetermination of eligibility.

(2) If the information discovered results in the Department finding the applicant or recipient ineligible for assistance, the Department shall provide notice as set forth in Section 11-7 of this Article.

(3) If the information discovered is insufficient to determine that the applicant or recipient is eligible or ineligible, the Department shall provide written notice to

the applicant or recipient which shall describe in sufficient detail the circumstances of the discrepancy, the information or documentation required, the manner in which the applicant or recipient may respond, and the consequences of failing to take action. The applicant or recipient shall have 10 business days to respond.

(4) If the applicant or recipient does not respond to the notice, the Department shall deny assistance for failure to cooperate, in which case the Department shall provide notice as set forth in Section 11-7. Eligibility for assistance shall not be established until the discrepancy has been resolved.

(5) If an applicant or recipient responds to the notice, the Department shall determine the effect of the information or documentation provided on the applicant's or recipient's case and shall take appropriate action. Written notice of the Department's action shall be provided as set forth in Section 11-7 of this Article.

(6) Suspected cases of fraud shall be referred to the Department's Inspector General.

(e) The Department shall adopt any rules necessary to implement this Section.

(305 ILCS 5/11-5.3 new)

Sec. 11-5.3. Procurement of vendor to verify eligibility for assistance under Article V.

(a) No later than 60 days after the effective date of this amendatory Act of the 97th General Assembly, the Chief Procurement Officer for General Services, in consultation with the Department of Healthcare and Family Services, shall conduct and complete any procurement necessary to procure a vendor to verify eligibility for assistance under Article V of this Code. Such authority shall include procuring a vendor to assist the Chief Procurement Officer in conducting the procurement. The Chief Procurement Officer and the Department shall jointly negotiate final contract terms with a vendor selected by the Chief Procurement Officer. Within 30 days of selection of an eligibility verification vendor, the Department of Healthcare and Family Services shall enter into a contract with the selected vendor. The Department of Healthcare and Family Services and the Department of Human Services shall cooperate with and provide any information requested by the Chief Procurement Officer to conduct the procurement.

(b) Notwithstanding any other provision of law, any procurement or contract necessary to comply with this Section shall be exempt from: (i) the Illinois Procurement Code pursuant to Section 1-10(h) of the Illinois Procurement Code, except that bidders shall comply with the disclosure requirement in Sections 50-10.5(a) through (d), 50-13, 50-35, and 50-37 of the Illinois Procurement Code and a vendor awarded a contract under this Section shall comply with Section 50-37 of the Procurement Code; (ii) any administrative rules of this

State pertaining to procurement or contract formation; and (iii) any State or Department policies or procedures pertaining to procurement, contract formation, contract award, and Business Enterprise Program approval.

(c) Upon becoming operational, the contractor shall conduct data matches using the name, date of birth, address, and Social Security Number of each applicant and recipient against public records to verify eligibility. The contractor, upon preliminary determination that an enrollee is eligible or ineligible, shall notify the Department. Within 20 business days of such notification, the Department shall accept the recommendation or reject it with a stated reason. The Department shall retain final authority over eligibility determinations. The contractor shall keep a record of all preliminary determinations of ineligibility communicated to the Department. Within 30 days of the end of each calendar quarter, the Department and contractor shall file a joint report on a quarterly basis to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the Senate President, and the Senate Minority Leader. The report shall include, but shall not be limited to, monthly recommendations of preliminary determinations of eligibility or ineligibility communicated by the contractor, the actions taken on those preliminary determinations by the Department, and the stated reasons for those recommendations that the Department rejected.

(d) An eligibility verification vendor contract shall be awarded for an initial 2-year period with up to a maximum of 2 one-year renewal options. Nothing in this Section shall compel the award of a contract to a vendor that fails to meet the needs of the Department. A contract with a vendor to assist in the procurement shall be awarded for a period of time not to exceed 6 months.

(305 ILCS 5/11-13) (from Ch. 23, par. 11-13)

Sec. 11-13. Conditions For Receipt of Vendor Payments - Limitation Period For Vendor Action - Penalty For Violation. A vendor payment, as defined in Section 2-5 of Article II, shall constitute payment in full for the goods or services covered thereby. Acceptance of the payment by or in behalf of the vendor shall bar him from obtaining, or attempting to obtain, additional payment therefor from the recipient or any other person. A vendor payment shall not, however, bar recovery of the value of goods and services the obligation for which, under the rules and regulations of the Illinois Department, is to be met from the income and resources available to the recipient, and in respect to which the vendor payment of the Illinois Department or the local governmental unit represents supplementation of such available income and resources.

Vendors seeking to enforce obligations of a governmental unit or the Illinois Department for goods or services (1) furnished to or in behalf of recipients and (2) subject to a

vendor payment as defined in Section 2-5, shall commence their actions in the appropriate Circuit Court or the Court of Claims, as the case may require, within one year next after the cause of action accrued.

A cause of action accrues within the meaning of this Section upon the following date:

(1) If the vendor can prove that he submitted a bill for the service rendered to the Illinois Department or a governmental unit within 180 days after ~~12 months of~~ the date the service was rendered, then (a) upon the date the Illinois Department or a governmental unit mails to the vendor information that it is paying a bill in part or is refusing to pay a bill in whole or in part, or (b) upon the date one year following the date the vendor submitted such bill if the Illinois Department or a governmental unit fails to mail to the vendor such payment information within one year following the date the vendor submitted the bill; or

(2) If the vendor cannot prove that he submitted a bill for the service rendered within 180 days after ~~12 months of~~ the date the service was rendered, then upon the date 12 months following the date the vendor rendered the service to the recipient.

In the case of long term care facilities, where the Illinois Department initiates the monthly billing process for the vendor, the cause of action shall accrue 12 months after the last day of the month the service was rendered.

This paragraph governs only vendor payments as defined in this Code and as limited by regulations of the Illinois Department; it does not apply to goods or services purchased or contracted for by a recipient under circumstances in which the payment is to be made directly by the recipient.

Any vendor who accepts a vendor payment and who knowingly obtains or attempts to obtain additional payment for the goods or services covered by the vendor payment from the recipient or any other person shall be guilty of a Class B misdemeanor.

(Source: P.A. 86-430.)

(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 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 <u>provider type</u>

as determined by the Department ~~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.

(c) When the Department has requested that a recipient designate a primary provider type 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.

(d) When a recipient has been restricted to a designated primary provider type, the recipient may change the primary provider type:

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

(2) when the designated primary provider type notifies the Department that it wishes to withdraw from any obligation as primary provider type; 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, 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 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 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 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. 96-1501, eff. 1-25-11.)

(305 ILCS 5/12-4.25) (from Ch. 23, par. 12-4.25)

Sec. 12-4.25. Medical assistance program; vendor participation.

(A) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, and may deny, suspend, or recover payments, if after reasonable notice and opportunity for a hearing the Illinois Department finds:

(a) Such vendor is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its vendor agreement, which document shall be developed by the

Department as a result of negotiations with each vendor category, including physicians, hospitals, long term care facilities, pharmacists, optometrists, podiatrists and dentists setting forth the terms and conditions applicable to the participation of each vendor group in the program; or

(b) Such vendor has failed to keep or make available for inspection, audit or copying, after receiving a written request from the Illinois Department, such records regarding payments claimed for providing services. This section does not require vendors to make available patient records of patients for whom services are not reimbursed under this Code; or

(c) Such vendor has failed to furnish any information requested by the Department regarding payments for providing goods or services; or

(d) Such vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program; or

(e) Such vendor has furnished goods or services to a recipient which are (1) in excess of need ~~his or her needs~~, (2) harmful ~~to the recipient~~, or (3) of grossly inferior quality, all of such determinations to be based upon competent medical judgment and evaluations; or

(f) The vendor; a person with management

responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship which is a vendor; or a partner in a partnership which is a vendor, either:

(1) was previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or was terminated, suspended, or excluded from participation in another state or federal medical assistance or health care program ~~a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code~~; or

(2) was a person with management responsibility for a vendor previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in another state or federal ~~a~~ medical assistance or health care program ~~in another state that is of the same kind as the program of medical assistance provided under Article V of this Code,~~ during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(3) was an officer, or person owning, either

directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or federal medical assistance or health care program ~~in another state that is of the same kind as the program of medical assistance provided under Article V of this Code,~~ during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(4) was an owner of a sole proprietorship or partner of a partnership previously terminated, suspended, or excluded from participation in the Illinois medical assistance program, or terminated, suspended, or excluded from participation in a state or federal medical assistance or health care program ~~in another state that is of the same kind as the program of medical assistance provided under Article V of this Code,~~ during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(f-1) Such vendor has a delinquent debt owed to the Illinois Department; or

(g) The vendor; a person with management

responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor; an owner of a sole proprietorship which is a vendor; or a partner in a partnership which is a vendor, either:

(1) has engaged in practices prohibited by applicable federal or State law or regulation ~~relating to the medical assistance program~~; or

(2) was a person with management responsibility for a vendor at the time that such vendor engaged in practices prohibited by applicable federal or State law or regulation ~~relating to the medical assistance program~~; or

(3) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor at the time such vendor engaged in practices prohibited by applicable federal or State law or regulation ~~relating to the medical assistance program~~; or

(4) was an owner of a sole proprietorship or partner of a partnership which was a vendor at the time such vendor engaged in practices prohibited by applicable federal or State law or regulation ~~relating to the medical assistance program~~; or

(h) The direct or indirect ownership of the vendor

(including the ownership of a vendor that is a sole proprietorship, a partner's interest in a vendor that is a partnership, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor) has been transferred by an individual who is terminated, suspended, or excluded or barred from participating as a vendor to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(A-5) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, if, after reasonable notice and opportunity for a hearing, the Illinois Department finds that the vendor; a person with management responsibility for a vendor; an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor; an owner of a sole proprietorship that is a vendor; or a partner in a partnership that is a vendor has been convicted of an ~~a felony~~ offense based on fraud or willful misrepresentation related to any of the following:

(1) The medical assistance program under Article V of

this Code.

(2) A medical assistance or health care program in another state ~~that is of the same kind as the program of medical assistance provided under Article V of this Code~~.

(3) The Medicare program under Title XVIII of the Social Security Act.

(4) The provision of health care services.

(5) A violation of this Code, as provided in Article VIIIA, or another state or federal medical assistance program or health care program.

(A-10) The Illinois Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor, if, after reasonable notice and opportunity for a hearing, the Illinois Department finds that (i) the vendor, (ii) a person with management responsibility for a vendor, (iii) an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of a sole proprietorship that is a vendor, or (v) a partner in a partnership that is a vendor has been convicted of an ~~a felony~~ offense related to any of the following:

(1) Murder.

(2) A Class X felony under the Criminal Code of 1961.

(3) Sexual misconduct that may subject recipients to an undue risk of harm.

(4) A criminal offense that may subject recipients to an undue risk of harm.

(5) A crime of fraud or dishonesty.

(6) A crime involving a controlled substance.

(7) A misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct related to a health care program.

(A-15) The Illinois Department may deny the eligibility of any person, firm, corporation, association, agency, institution, or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V if, after reasonable notice and opportunity for a hearing, the Illinois Department finds:

(1) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership applicant; or a technical or other advisor to an applicant has a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by the applicant.

(2) The applicant or any person with management responsibility for the applicant; an officer or member of the board of directors of an applicant; an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor applicant; an owner of a sole proprietorship applicant; a partner in a partnership vendor applicant; or a technical or other advisor to an applicant was (i) a person with management responsibility, (ii) an officer or member of the board of directors of an applicant, (iii) an entity owning (directly or indirectly) 5% or more of the shares of stock or other evidences of ownership in a corporate vendor, (iv) an owner of a sole proprietorship, (v) a partner in a partnership vendor, (vi) a technical or other advisor to a vendor, during a period of time where the conduct of that vendor resulted in a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by that vendor.

(3) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant from a current or prior vendor who has a debt owed to the Illinois Department, no payment arrangements acceptable to the Illinois Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

(4) There is a credible allegation of a transfer of

management responsibilities, or direct or indirect ownership, to an applicant from a current or prior vendor who has a debt owed to the Illinois Department, and no payment arrangements acceptable to the Illinois Department have been made by that vendor or the vendor's alternate payee, and the applicant knows or should have known of such debt.

(5) There is a credible allegation of the use, transfer, or lease of assets of any kind to an applicant who is a spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, relative by marriage, nephew, cousin, or relative of a current or prior vendor who has a debt owed to the Illinois Department and no payment arrangements acceptable to the Illinois Department have been made.

(6) There is a credible allegation that the applicant's previous affiliations with a provider of medical services that has an uncollected debt, a provider that has been or is subject to a payment suspension under a federal health care program, or a provider that has been previously excluded from participation in the medical assistance program, poses a risk of fraud, waste, or abuse to the Illinois Department.

As used in this subsection, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data

mining, patterns identified through provider audits, civil actions filed under the False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability.

(B) The Illinois Department shall deny, suspend or terminate the eligibility of any person, firm, corporation, association, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V, or may exclude any such person or entity from participation as such a vendor:

(1) immediately, if such vendor is not properly licensed, certified, or authorized;

(2) within 30 days of the date when such vendor's professional license, certification or other authorization has been refused renewal, restricted, ~~or has been~~ revoked, suspended, or otherwise terminated; or

(3) if such vendor has been convicted of a violation of this Code, as provided in Article VIIIA.

(C) Upon termination, suspension, or exclusion of a vendor of goods or services from participation in the medical assistance program authorized by this Article, a person with management responsibility for such vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion is barred from participation in the medical assistance program.

Upon termination, suspension, or exclusion of a corporate vendor, the officers and persons owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in the vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion are barred from participation in the medical assistance program. A person who owns, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a terminated, suspended, or excluded ~~corporate~~ vendor may not transfer his or her ownership interest in that vendor to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

Upon termination, suspension, or exclusion of a sole proprietorship or partnership, the owner or partners during the time of any conduct which served as the basis for that vendor's termination, suspension, or exclusion are barred from participation in the medical assistance program. The owner of a terminated, suspended, or excluded vendor that is a sole proprietorship, and a partner in a terminated, suspended, or excluded vendor that is a partnership, may not transfer his or her ownership or partnership interest in that vendor to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

A person who owns, directly or indirectly, 5% or more of

the shares of stock or other evidences of ownership in a corporate or limited liability company vendor who owes a debt to the Department, if that vendor has not made payment arrangements acceptable to the Department, shall not transfer his or her ownership interest in that vendor, or vendor assets of any kind, to his or her spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

Rules adopted by the Illinois Department to implement these provisions shall specifically include a definition of the term "management responsibility" as used in this Section. Such definition shall include, but not be limited to, typical job titles, and duties and descriptions which will be considered as within the definition of individuals with management responsibility for a provider.

A vendor or a prior vendor who has been terminated, excluded, or suspended from the medical assistance program, or from another state or federal medical assistance or health care program, and any individual currently or previously barred from the medical assistance program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly, or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate or limited liability company vendor during the time of any conduct which served as the basis for that vendor's termination, suspension, or

exclusion, may be required to post a surety bond as part of a condition of enrollment or participation in the medical assistance program. The Illinois Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

A vendor or a prior vendor who has a debt owed to the Illinois Department and any individual currently or previously barred from the medical assistance program, or from another state or federal medical assistance or health care program, as a result of being an officer or a person owning, directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in that corporate or limited liability company vendor during the time of any conduct which served as the basis for the debt, may be required to post a surety bond as part of a condition of enrollment or participation in the medical assistance program. The Illinois Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

(D) If a vendor has been suspended from the medical assistance program under Article V of the Code, the Director may require that such vendor correct any deficiencies which served as the basis for the suspension. The Director shall specify in the suspension order a specific period of time, which shall not exceed one year from the date of the order, during which a suspended vendor shall not be eligible to

participate. At the conclusion of the period of suspension the Director shall reinstate such vendor, unless he finds that such vendor has not corrected deficiencies upon which the suspension was based.

If a vendor has been terminated, suspended, or excluded from the medical assistance program under Article V, such vendor shall be barred from participation for at least one year, except that if a vendor has been terminated, suspended, or excluded based on a conviction of a violation of Article VIIIA or a conviction of a felony based on fraud or a willful misrepresentation related to (i) the medical assistance program under Article V, (ii) a federal or another state's medical assistance or health care program ~~in another state that is of the kind provided under Article V, (iii) the Medicare program under Title XVIII of the Social Security Act~~, or (iii) ~~(iv)~~ the provision of health care services, then the vendor shall be barred from participation for 5 years or for the length of the vendor's sentence for that conviction, whichever is longer. At the end of one year a vendor who has been terminated, suspended, or excluded may apply for reinstatement to the program. Upon proper application to be reinstated such vendor may be deemed eligible by the Director providing that such vendor meets the requirements for eligibility under this Code. If such vendor is deemed not eligible for reinstatement, he shall be barred from again applying for reinstatement for one year from the date his application for reinstatement is

denied.

A vendor whose termination, suspension, or exclusion from participation in the Illinois medical assistance program under Article V was based solely on an action by a governmental entity other than the Illinois Department may, upon reinstatement by that governmental entity or upon reversal of the termination, suspension, or exclusion, apply for rescission of the termination, suspension, or exclusion from participation in the Illinois medical assistance program. Upon proper application for rescission, the vendor may be deemed eligible by the Director if the vendor meets the requirements for eligibility under this Code.

If a vendor has been terminated, suspended, or excluded and reinstated to the medical assistance program under Article V and the vendor is terminated, suspended, or excluded a second or subsequent time from the medical assistance program, the vendor shall be barred from participation for at least 2 years, except that if a vendor has been terminated, suspended, or excluded a second time based on a conviction of a violation of Article VIIIA or a conviction of a felony based on fraud or a willful misrepresentation related to (i) the medical assistance program under Article V, (ii) a federal or another state's medical assistance or health care program ~~in another state that is of the kind provided under Article V, (iii) the Medicare program under Title XVIII of the Social Security Act~~, or (iii) ~~(iv)~~ the provision of health care services, then the

vendor shall be barred from participation for life. At the end of 2 years, a vendor who has been terminated, suspended, or excluded may apply for reinstatement to the program. Upon application to be reinstated, the vendor may be deemed eligible if the vendor meets the requirements for eligibility under this Code. If the vendor is deemed not eligible for reinstatement, the vendor shall be barred from again applying for reinstatement for 2 years from the date the vendor's application for reinstatement is denied.

(E) The Illinois Department may recover money improperly or erroneously paid, or overpayments, either by setoff, crediting against future billings or by requiring direct repayment to the Illinois Department. The Illinois Department may suspend or deny payment, in whole or in part, if such payment would be improper or erroneous or would otherwise result in overpayment.

(1) Payments may be suspended, denied, or recovered from a vendor or alternate payee: (i) for services rendered in violation of the Illinois Department's provider notices, statutes, rules, and regulations; (ii) for services rendered in violation of the terms and conditions prescribed by the Illinois Department in its vendor agreement; (iii) for any vendor who fails to grant the Office of Inspector General timely access to full and complete records, including, but not limited to, records relating to recipients under the medical assistance program for the most recent 6 years, in accordance with

Section 140.28 of Title 89 of the Illinois Administrative Code, and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General; this subsection (E) does not require vendors to make available the medical records of patients for whom services are not reimbursed under this Code or to provide access to medical records more than 6 years old; (iv) when the vendor has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program; or (v) when the vendor previously rendered services while terminated, suspended, or excluded from participation in the medical assistance program or while terminated or excluded from participation in another state or federal medical assistance or health care program.

(2) Notwithstanding any other provision of law, if a vendor has the same taxpayer identification number (assigned under Section 6109 of the Internal Revenue Code of 1986) as is assigned to a vendor with past-due financial obligations to the Illinois Department, the Illinois Department may make any necessary adjustments to payments to that vendor in order to satisfy any past-due obligations, regardless of whether the vendor is assigned a different billing number under the medical assistance program.

If the Illinois Department establishes through an administrative hearing that the overpayments resulted from the vendor or alternate payee knowingly ~~willfully~~ making, using, or causing to be made or used, a false record or statement to obtain payment or other benefit from ~~or misrepresentation of a material fact in connection with billings and payments under~~ the medical assistance program under Article V, the Department may recover interest on the amount of the payment or other benefit ~~overpayments~~ at the rate of 5% per annum. In addition to any other penalties that may be prescribed by law, such a vendor or alternate payee shall be subject to civil penalties consisting of an amount not to exceed 3 times the amount of payment or other benefit resulting from each such false record or statement, and the sum of $2,000 for each such false record or statement for payment or other benefit. For purposes of this paragraph, "knowingly" ~~"willfully"~~ means that a vendor or alternate payee with respect to information: (i) has ~~person makes a statement or representation with~~ actual knowledge of the information, (ii) acts in deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required. ~~that it was false, or makes a statement or representation with knowledge of facts or information that would cause one to be aware that the statement or representation was false when made.~~

(F) The Illinois Department may withhold payments to any

vendor or alternate payee prior to or during the pendency of any audit or proceeding under this Section, and through the pendency of any administrative appeal or administrative review by any court proceeding. The Illinois Department shall state by rule with as much specificity as practicable the conditions under which payments will not be withheld ~~during the pendency of any proceeding~~ under this Section. Payments may be denied for bills submitted with service dates occurring during the pendency of a proceeding, after a final decision has been rendered, or after the conclusion of any administrative appeal, where the final administrative decision is to terminate, exclude, or suspend eligibility to participate in the medical assistance program. The Illinois Department shall state by rule with as much specificity as practicable the conditions under which payments will not be denied for such bills. The Illinois Department shall state by rule a process and criteria by which a vendor or alternate payee may request full or partial release of payments withheld under this subsection. The Department must complete a proceeding under this Section in a timely manner.

Notwithstanding recovery allowed under subsection (E) or this subsection (F), the Illinois Department may withhold payments to any vendor or alternate payee who is not properly licensed, certified, or in compliance with State or federal agency regulations. Payments may be denied for bills submitted with service dates occurring during the period of time that a vendor is not properly licensed, certified, or in compliance

with State or federal regulations. Facilities licensed under the Nursing Home Care Act shall have payments denied or withheld pursuant to subsection (I) of this Section.

(F-5) The Illinois Department may temporarily withhold payments to a vendor or alternate payee if any of the following individuals have been indicted or otherwise charged under a law of the United States or this or any other state with an ~~a felony~~ offense that is based on alleged fraud or willful misrepresentation on the part of the individual related to (i) the medical assistance program under Article V of this Code, (ii) a federal or another state's medical assistance or health care program ~~provided in another state which is of the kind provided under Article V of this Code, (iii) the Medicare program under Title XVIII of the Social Security Act~~, or (iii) ~~(iv)~~ the provision of health care services:

(1) If the vendor or alternate payee is a corporation: an officer of the corporation or an individual who owns, either directly or indirectly, 5% or more of the shares of stock or other evidence of ownership of the corporation.

(2) If the vendor is a sole proprietorship: the owner of the sole proprietorship.

(3) If the vendor or alternate payee is a partnership: a partner in the partnership.

(4) If the vendor or alternate payee is any other business entity authorized by law to transact business in this State: an officer of the entity or an individual who

owns, either directly or indirectly, 5% or more of the evidences of ownership of the entity.

If the Illinois Department withholds payments to a vendor or alternate payee under this subsection, the Department shall not release those payments to the vendor or alternate payee while any criminal proceeding related to the indictment or charge is pending unless the Department determines that there is good cause to release the payments before completion of the proceeding. If the indictment or charge results in the individual's conviction, the Illinois Department shall retain all withheld payments, which shall be considered forfeited to the Department. If the indictment or charge does not result in the individual's conviction, the Illinois Department shall release to the vendor or alternate payee all withheld payments.

(F-10) If the Illinois Department establishes that the vendor or alternate payee owes a debt to the Illinois Department, and the vendor or alternate payee subsequently fails to pay or make satisfactory payment arrangements with the Illinois Department for the debt owed, the Illinois Department may seek all remedies available under the law of this State to recover the debt, including, but not limited to, wage garnishment or the filing of claims or liens against the vendor or alternate payee.

(F-15) Enforcement of judgment.

(1) Any fine, recovery amount, other sanction, or costs imposed, or part of any fine, recovery amount, other

sanction, or cost imposed, remaining unpaid after the exhaustion of or the failure to exhaust judicial review procedures under the Illinois Administrative Review Law is a debt due and owing the State and may be collected using all remedies available under the law.

(2) After expiration of the period in which judicial review under the Illinois Administrative Review Law may be sought for a final administrative decision, unless stayed by a court of competent jurisdiction, the findings, decision, and order of the Director may be enforced in the same manner as a judgment entered by a court of competent jurisdiction.

(3) In any case in which any person or entity has failed to comply with a judgment ordering or imposing any fine or other sanction, any expenses incurred by the Illinois Department to enforce the judgment, including, but not limited to, attorney's fees, court costs, and costs related to property demolition or foreclosure, after they are fixed by a court of competent jurisdiction or the Director, shall be a debt due and owing the State and may be collected in accordance with applicable law. Prior to any expenses being fixed by a final administrative decision pursuant to this subsection (F-15), the Illinois Department shall provide notice to the individual or entity that states that the individual or entity shall appear at a hearing before the administrative hearing officer to

determine whether the individual or entity has failed to comply with the judgment. The notice shall set the date for such a hearing, which shall not be less than 7 days from the date that notice is served. If notice is served by mail, the 7-day period shall begin to run on the date that the notice was deposited in the mail.

(4) Upon being recorded in the manner required by Article XII of the Code of Civil Procedure or by the Uniform Commercial Code, a lien shall be imposed on the real estate or personal estate, or both, of the individual or entity in the amount of any debt due and owing the State under this Section. The lien may be enforced in the same manner as a judgment of a court of competent jurisdiction. 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.

(5) The Director may set aside any judgment entered by default and set a new hearing date upon a petition filed at any time (i) if the petitioner's failure to appear at the hearing was for good cause, or (ii) if the petitioner established that the Department did not provide proper service of process. If any judgment is set aside pursuant to this paragraph (5), the hearing officer shall have authority to enter an order extinguishing any lien which has been recorded for any debt due and owing the Illinois

Department as a result of the vacated default judgment.

(G) The provisions of the Administrative Review Law, as now or hereafter amended, and the rules adopted pursuant thereto, shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Illinois Department under this Section. The term "administrative decision" is defined as in Section 3-101 of the Code of Civil Procedure.

(G-5) Vendors who pose a risk of fraud, waste, abuse, or harm ~~Non-emergency transportation~~.

(1) Notwithstanding any other provision in this Section, ~~for non-emergency transportation vendors,~~ the Department may terminate, suspend, or exclude vendors who pose a risk of fraud, waste, abuse, or harm ~~the vendor~~ from participation in the medical assistance program prior to an evidentiary hearing but after reasonable notice and opportunity to respond as established by the Department by rule.

(2) Vendors who pose a risk of fraud, waste, abuse, or harm ~~of non-emergency medical transportation services, as defined by the Department by rule,~~ shall submit to a fingerprint-based criminal background check on current and future information available in the State system and current information available through the Federal Bureau of Investigation's system by submitting all necessary fees and information in the form and manner prescribed by the

Department of State Police. The following individuals shall be subject to the check:

(A) In the case of a vendor that is a corporation, every shareholder who owns, directly or indirectly, 5% or more of the outstanding shares of the corporation.

(B) In the case of a vendor that is a partnership, every partner.

(C) In the case of a vendor that is a sole proprietorship, the sole proprietor.

(D) Each officer or manager of the vendor.

Each such vendor shall be responsible for payment of the cost of the criminal background check.

(3) Vendors who pose a risk of fraud, waste, abuse, or harm ~~of non-emergency medical transportation services~~ may be required to post a surety bond. The Department shall establish, by rule, the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

(4) The Department, or its agents, may refuse to accept requests for authorization from specific vendors who pose a risk of fraud, waste, abuse, or harm ~~non-emergency transportation authorizations~~, including prior-approval and post-approval requests, ~~for a specific non-emergency transportation vendor~~ if:

(A) the Department has initiated a notice of termination, suspension, or exclusion of the vendor

from participation in the medical assistance program; or

(B) the Department has issued notification of its withholding of payments pursuant to subsection (F-5) of this Section; or

(C) the Department has issued a notification of its withholding of payments due to reliable evidence of fraud or willful misrepresentation pending investigation.

(5) As used in this subsection, the following terms are defined as follows:

(A) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

(B) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to the medical assistance program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the medical assistance program. Abuse does not include diagnostic or therapeutic

measures conducted primarily as a safeguard against possible vendor liability.

(C) "Waste" means the unintentional misuse of medical assistance resources, resulting in unnecessary cost to the medical assistance program. Waste does not include diagnostic or therapeutic measures conducted primarily as a safeguard against possible vendor liability.

(D) "Harm" means physical, mental, or monetary damage to recipients or to the medical assistance program.

(G-6) The Illinois Department, upon making a determination based upon information in the possession of the Illinois Department that continuation of participation in the medical assistance program by a vendor would constitute an immediate danger to the public, may immediately suspend such vendor's participation in the medical assistance program without a hearing. In instances in which the Illinois Department immediately suspends the medical assistance program participation of a vendor under this Section, a hearing upon the vendor's participation must be convened by the Illinois Department within 15 days after such suspension and completed without appreciable delay. Such hearing shall be held to determine whether to recommend to the Director that the vendor's medical assistance program participation be denied, terminated, suspended, placed on provisional status, or

reinstated. In the hearing, any evidence relevant to the vendor constituting an immediate danger to the public may be introduced against such vendor; provided, however, that the vendor, or his or her counsel, shall have the opportunity to discredit, impeach, and submit evidence rebutting such evidence.

(H) Nothing contained in this Code shall in any way limit or otherwise impair the authority or power of any State agency responsible for licensing of vendors.

(I) Based on a finding of noncompliance on the part of a nursing home with any requirement for certification under Title XVIII or XIX of the Social Security Act (42 U.S.C. Sec. 1395 et seq. or 42 U.S.C. Sec. 1396 et seq.), the Illinois Department may impose one or more of the following remedies after notice to the facility:

(1) Termination of the provider agreement.

(2) Temporary management.

(3) Denial of payment for new admissions.

(4) Civil money penalties.

(5) Closure of the facility in emergency situations or transfer of residents, or both.

(6) State monitoring.

(7) Denial of all payments when the U.S. Department of Health and Human Services ~~Health Care Finance Administration~~ has imposed this sanction.

The Illinois Department shall by rule establish criteria

governing continued payments to a nursing facility subsequent to termination of the facility's provider agreement if, in the sole discretion of the Illinois Department, circumstances affecting the health, safety, and welfare of the facility's residents require those continued payments. The Illinois Department may condition those continued payments on the appointment of temporary management, sale of the facility to new owners or operators, or other arrangements that the Illinois Department determines best serve the needs of the facility's residents.

Except in the case of a facility that has a right to a hearing on the finding of noncompliance before an agency of the federal government, a facility may request a hearing before a State agency on any finding of noncompliance within 60 days after the notice of the intent to impose a remedy. Except in the case of civil money penalties, a request for a hearing shall not delay imposition of the penalty. The choice of remedies is not appealable at a hearing. The level of noncompliance may be challenged only in the case of a civil money penalty. The Illinois Department shall provide by rule for the State agency that will conduct the evidentiary hearings.

The Illinois Department may collect interest on unpaid civil money penalties.

The Illinois Department may adopt all rules necessary to implement this subsection (I).

(J) The Illinois Department, by rule, may permit individual practitioners to designate that Department payments that may be due the practitioner be made to an alternate payee or alternate payees.

(a) Such alternate payee or alternate payees shall be required to register as an alternate payee in the Medical Assistance Program with the Illinois Department.

(b) If a practitioner designates an alternate payee, the alternate payee and practitioner shall be jointly and severally liable to the Department for payments made to the alternate payee. Pursuant to subsection (E) of this Section, any Department action to <u>suspend or deny payment or</u> recover money or overpayments from an alternate payee shall be subject to an administrative hearing.

(c) Registration as an alternate payee or alternate payees in the Illinois Medical Assistance Program shall be conditional. At any time, the Illinois Department may deny or cancel any alternate payee's registration in the Illinois Medical Assistance Program without cause. Any such denial or cancellation is not subject to an administrative hearing.

(d) The Illinois Department may seek a revocation of any alternate payee, and all owners, officers, and individuals with management responsibility for such alternate payee shall be permanently prohibited from participating as an owner, an officer, or an individual

with management responsibility with an alternate payee in the Illinois Medical Assistance Program, if after reasonable notice and opportunity for a hearing the Illinois Department finds that:

(1) the alternate payee is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its alternate payee registration agreement; or

(2) the alternate payee has failed to keep or make available for inspection, audit, or copying, after receiving a written request from the Illinois Department, such records regarding payments claimed as an alternate payee; or

(3) the alternate payee has failed to furnish any information requested by the Illinois Department regarding payments claimed as an alternate payee; or

(4) the alternate payee has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Illinois Medical Assistance Program; or

(5) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of

ownership in a corporate alternate payee, or a partner in a partnership which is an alternate payee:

(a) was previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code; or

(b) was a person with management responsibility for a vendor previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion or alternate payee's revocation; or

(c) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate vendor previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of conduct which was the basis for that vendor's termination, suspension, or exclusion; or

(d) was an owner of a sole proprietorship or partner in a partnership previously terminated, suspended, or excluded from participation as a vendor in the Illinois Medical Assistance Program, or was previously revoked as an alternate payee in the Illinois Medical Assistance Program, or was terminated, suspended, or excluded from participation as a vendor in a medical assistance program in another state that is of the same kind as the program of medical assistance provided under Article V of this Code, during the time of

conduct which was the basis for that vendor's termination, suspension, or exclusion or alternate payee's revocation; or

(6) the alternate payee, a person with management responsibility for an alternate payee, an officer or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a corporate alternate payee, or a partner in a partnership which is an alternate payee:

(a) has engaged in conduct prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(b) was a person with management responsibility for a vendor or alternate payee at the time that the vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(c) was an officer, or person owning, either directly or indirectly, 5% or more of the shares of stock or other evidences of ownership in a vendor or alternate payee at the time such vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance

Program; or

(d) was an owner of a sole proprietorship or partner in a partnership which was a vendor or alternate payee at the time such vendor or alternate payee engaged in practices prohibited by applicable federal or State law or regulation relating to the Illinois Medical Assistance Program; or

(7) the direct or indirect ownership of the vendor or alternate payee (including the ownership of a vendor or alternate payee that is a partner's interest in a vendor or alternate payee, or ownership of 5% or more of the shares of stock or other evidences of ownership in a corporate vendor or alternate payee) has been transferred by an individual who is terminated, suspended, or excluded or barred from participating as a vendor or is prohibited or revoked as an alternate payee to the individual's spouse, child, brother, sister, parent, grandparent, grandchild, uncle, aunt, niece, nephew, cousin, or relative by marriage.

(K) The Illinois Department of Healthcare and Family Services may withhold payments, in whole or in part, to a provider or alternate payee where there is credible ~~upon receipt of~~ evidence, received from State or federal law enforcement or federal oversight agencies or from the results of a preliminary Department audit ~~and determined by the~~

~~Department to be credible~~, that the circumstances giving rise to the need for a withholding of payments may involve fraud or willful misrepresentation under the Illinois Medical Assistance program. The Department shall by rule define what constitutes "credible" evidence for purposes of this subsection. The Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments. A provider or alternate payee may request a reconsideration of payment withholding, and the Department must grant such a request. The Department shall state by rule a process and criteria by which a provider or alternate payee may request full or partial release of payments withheld under this subsection. This request may be made at any time after the Department first withholds such payments.

(a) The Illinois Department must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must do all of the following:

(1) State that payments are being withheld in accordance with this subsection.

(2) State that the withholding is for a temporary period, as stated in paragraph (b) of this subsection, and cite the circumstances under which withholding

will be terminated.

(3) Specify, when appropriate, which type or types of Medicaid claims withholding is effective.

(4) Inform the provider or alternate payee of the right to submit written evidence for reconsideration of the withholding by the Illinois Department.

(5) Inform the provider or alternate payee that a written request may be made to the Illinois Department for full or partial release of withheld payments and that such requests may be made at any time after the Department first withholds such payments.

(b) All withholding-of-payment actions under this subsection shall be temporary and shall not continue after any of the following:

(1) The Illinois Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider or alternate payee.

(2) Legal proceedings related to the provider's or alternate payee's alleged fraud, willful misrepresentation, violations of this Act, or violations of the Illinois Department's administrative rules are completed.

(3) The withholding of payments for a period of 3 years.

(c) The Illinois Department may adopt all rules

necessary to implement this subsection (K).

(K-5) The Illinois Department may withhold payments, in whole or in part, to a provider or alternate payee upon initiation of an audit, quality of care review, investigation when there is a credible allegation of fraud, or the provider or alternate payee demonstrating a clear failure to cooperate with the Illinois Department such that the circumstances give rise to the need for a withholding of payments. As used in this subsection, "credible allegation" is defined to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the False Claims Act, and law enforcement investigations. An allegation is considered to be credible when it has indicia of reliability. The Illinois Department may withhold payments without first notifying the provider or alternate payee of its intention to withhold such payments. A provider or alternate payee may request a hearing or a reconsideration of payment withholding, and the Illinois Department must grant such a request. The Illinois Department shall state by rule a process and criteria by which a provider or alternate payee may request a hearing or a reconsideration for the full or partial release of payments withheld under this subsection. This request may be made at any time after the Illinois Department first withholds such payments.

(a) The Illinois Department must send notice of its

withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action but need not disclose any specific information concerning its ongoing investigation. The notice must do all of the following:

(1) State that payments are being withheld in accordance with this subsection.

(2) State that the withholding is for a temporary period, as stated in paragraph (b) of this subsection, and cite the circumstances under which withholding will be terminated.

(3) Specify, when appropriate, which type or types of claims are withheld.

(4) Inform the provider or alternate payee of the right to request a hearing or a reconsideration of the withholding by the Illinois Department, including the ability to submit written evidence.

(5) Inform the provider or alternate payee that a written request may be made to the Illinois Department for a hearing or a reconsideration for the full or partial release of withheld payments and that such requests may be made at any time after the Illinois Department first withholds such payments.

(b) All withholding of payment actions under this subsection shall be temporary and shall not continue after

any of the following:

(1) The Illinois Department determines that there is insufficient evidence of fraud, or the provider or alternate payee demonstrates clear cooperation with the Illinois Department, as determined by the Illinois Department, such that the circumstances do not give rise to the need for withholding of payments; or

(2) The withholding of payments has lasted for a period in excess of 3 years.

(c) The Illinois Department may adopt all rules necessary to implement this subsection (K-5).

(L) The Illinois Department shall establish a protocol to enable health care providers to disclose an actual or potential violation of this Section pursuant to a self-referral disclosure protocol, referred to in this subsection as "the protocol". The protocol shall include direction for health care providers on a specific person, official, or office to whom such disclosures shall be made. The Illinois Department shall post information on the protocol on the Illinois Department's public website. The Illinois Department may adopt rules necessary to implement this subsection (L). In addition to other factors that the Illinois Department finds appropriate, the Illinois Department may consider a health care provider's timely use or failure to use the protocol in considering the provider's failure to comply with this Code.

(M) Notwithstanding any other provision of this Code, the

Illinois Department, at its discretion, may exempt an entity licensed under the Nursing Home Care Act and the ID/DD Community Care Act from the provisions of subsections (A-15), (B), and (C) of this Section if the licensed entity is in receivership.

(Source: P.A. 94-265, eff. 1-1-06; 94-975, eff. 6-30-06.)

(305 ILCS 5/12-4.38)

Sec. 12-4.38. Special FamilyCare provisions. ~~(a)~~ The Department of Healthcare and Family Services may submit to the Comptroller, and the Comptroller is authorized to pay, on behalf of persons enrolled in the FamilyCare Program, claims for services rendered to an enrollee during the period beginning October 1, 2007, and ending on the effective date of any rules adopted to implement the provisions of this amendatory Act of the 96th General Assembly. The authorization for payment of claims applies only to bona fide claims for payment for services rendered. Any claim for payment which is authorized pursuant to the provisions of this amendatory Act of the 96th General Assembly must adhere to all other applicable rules, regulations, and requirements.

~~(b) Each person enrolled in the FamilyCare Program as of the effective date of this amendatory Act of the 96th General Assembly whose income exceeds 185% of the Federal Poverty Level, but is not more than 400% of the Federal Poverty Level, may remain enrolled in the FamilyCare Program pursuant to this~~

~~subsection so long as that person continues to meet the eligibility criteria established under the emergency rule at 89 Ill. Adm. Code 120 (Illinois Register Volume 31, page 15854) filed November 7, 2007. In no case may a person continue to be enrolled in the FamilyCare Program pursuant to this subsection if the person's income rises above 400% of the Federal Poverty Level or falls below 185% of the Federal Poverty Level at any subsequent time. Nothing contained in this subsection shall prevent an individual from enrolling in the FamilyCare Program as authorized by paragraph 15 of Section 5-2 of this Code if he or she otherwise qualifies under that Section.~~

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

(Source: P.A. 96-20, eff. 6-30-09.)

(305 ILCS 5/12-4.39)

Sec. 12-4.39. Dental clinic grant program.

(a) Grant program. On and after July 1, 2012, and subject ~~Subject~~ to funding availability, the Department of Healthcare and Family Services may ~~shall~~ administer a grant program. The purpose of this grant program shall be to build the public infrastructure for dental care and to make grants to local health departments, federally qualified health clinics (FQHCs), and rural health clinics (RHCs) for development of comprehensive dental clinics for dental care services. The primary purpose of these new dental clinics will be to increase dental access for low-income and Department of Healthcare and Family Services clients who have no dental arrangements with a dental provider in a project's service area. The dental clinic must be willing to accept out-of-area clients who need dental services, including emergency services for adults and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-referral children. Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs) shall receive special priority for grants under this program.

(b) Eligible applicants. The following entities are eligible to apply for grants:

(1) Local health departments.

(2) Federally Qualified Health Centers (FQHCs).

(3) Rural health clinics (RHCs).

(c) Use of grant moneys. Grant moneys must be used to support projects that develop dental services to meet the dental health care needs of Department of Healthcare and Family

Services Dental Program clients. Grant moneys must be used for operating expenses, including, but not limited to: insurance; dental supplies and equipment; dental support services; and renovation expenses. Grant moneys may not be used to offset existing indebtedness, supplant existing funds, purchase real property, or pay for personnel service salaries for dental employees.

(d) Application process. The Department shall establish procedures for applying for dental clinic grants.

(Source: P.A. 96-67, eff. 7-23-09; 96-1000, eff. 7-2-10.)

(305 ILCS 5/12-10.5)

Sec. 12-10.5. Medical Special Purposes Trust Fund.

(a) The Medical Special Purposes Trust Fund ("the Fund") is created. Any grant, gift, donation, or legacy of money or securities that the Department of Healthcare and Family Services is authorized to receive under Section 12-4.18 or Section 12-4.19 or any monies from any other source, and that are ~~is~~ dedicated for functions connected with the administration of any medical program administered by the Department, shall be deposited into the Fund. All federal moneys received by the Department as reimbursement for disbursements authorized to be made from the Fund shall also be deposited into the Fund. In addition, federal moneys received on account of State expenditures made in connection with obtaining compliance with the federal Health Insurance

Portability and Accountability Act (HIPAA) shall be deposited into the Fund.

(b) No moneys received from a service provider or a governmental or private entity that is enrolled with the Department as a provider of medical services shall be deposited into the Fund.

(c) Disbursements may be made from the Fund for the purposes connected with the grants, gifts, donations, ~~or~~ legacies, or other monies deposited into the Fund, including, but not limited to, medical quality assessment projects, eligibility population studies, medical information systems evaluations, and other administrative functions that assist the Department in fulfilling its health care mission under any medical program administered by the Department.

(Source: P.A. 97-48, eff. 6-28-11.)

(305 ILCS 5/12-13.1)

Sec. 12-13.1. Inspector General.

(a) The Governor shall appoint, and the Senate shall confirm, an Inspector General who shall function within the Illinois Department of Public Aid (now Healthcare and Family Services) and report to the Governor. The term of the Inspector General shall expire on the third Monday of January, 1997 and every 4 years thereafter.

(b) In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct, the Inspector

General shall oversee the Department of Healthcare and Family Services' integrity functions, which include, but are not limited to, the following:

(1) Investigation of misconduct by employees, vendors, contractors and medical providers, except for allegations of violations of the State Officials and Employees Ethics Act which shall be referred to the Office of the Governor's Executive Inspector General for investigation.

(2) Prepayment and post-payment audits ~~Audits~~ of medical providers related to ensuring that appropriate payments are made for services rendered and to the prevention and recovery of overpayments.

(3) Monitoring of quality assurance programs administered by the Department of Healthcare and Family Services ~~generally related to the medical assistance program and specifically related to any managed care program~~.

(4) Quality control measurements of the programs administered by the Department of Healthcare and Family Services.

(5) Investigations of fraud or intentional program violations committed by clients of the Department of Healthcare and Family Services.

(6) Actions initiated against contractors, vendors, or medical providers for any of the following reasons:

(A) Violations of the medical assistance program.

(B) Sanctions against providers brought in conjunction with the Department of Public Health or the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities).

(C) Recoveries of assessments against hospitals and long-term care facilities.

(D) Sanctions mandated by the United States Department of Health and Human Services against medical providers.

(E) Violations of contracts related to any programs administered by the Department of Healthcare and Family Services ~~managed care programs~~.

(7) Representation of the Department of Healthcare and Family Services at hearings with the Illinois Department of Financial and Professional Regulation in actions taken against professional licenses held by persons who are in violation of orders for child support payments.

(b-5) At the request of the Secretary of Human Services, the Inspector General shall, in relation to any function performed by the Department of Human Services as successor to the Department of Public Aid, exercise one or more of the powers provided under this Section as if those powers related to the Department of Human Services; in such matters, the Inspector General shall report his or her findings to the Secretary of Human Services.

(c) Notwithstanding, and in addition to, any other provision of law, the ~~The~~ Inspector General shall have access to all information, personnel and facilities of the Department of Healthcare and Family Services and the Department of Human Services (as successor to the Department of Public Aid), their employees, vendors, contractors and medical providers and any federal, State or local governmental agency that are necessary to perform the duties of the Office as directly related to public assistance programs administered by those departments. No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the programs administered by the Department of Healthcare and Family Services ~~Medical Assistance Program~~. State and local governmental agencies are authorized and directed to provide the requested information, assistance or cooperation.

For purposes of enhanced program integrity functions and oversight, and to the extent consistent with applicable information and privacy, security, and disclosure laws, State agencies and departments shall provide the Office of Inspector General access to confidential and other information and data, and the Inspector General is authorized to enter into agreements with appropriate federal agencies and departments to secure similar data. This includes, but is not limited to, information pertaining to: licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental

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

The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies shall share data necessary for recipient and vendor screening, review, and investigation, including but not limited to vendor payment and recipient eligibility verification. The Inspector General shall develop, in cooperation with other State and federal agencies and departments, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and

Professional Regulation.

The Inspector General shall have the authority to deny payment, prevent overpayments, and recover overpayments.

The Inspector General shall have the authority to deny or suspend payment to, and deny, terminate, or suspend the eligibility of, any vendor who fails to grant the Inspector General timely access to full and complete records, including records of recipients under the medical assistance program for the most recent 6 years, in accordance with Section 140.28 of Title 89 of the Illinois Administrative Code, and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General.

(d) The Inspector General shall serve as the Department of Healthcare and Family Services' primary liaison with law enforcement, investigatory and prosecutorial agencies, including but not limited to the following:

(1) The Department of State Police.

(2) The Federal Bureau of Investigation and other federal law enforcement agencies.

(3) The various Inspectors General of federal agencies overseeing the programs administered by the Department of Healthcare and Family Services.

(4) The various Inspectors General of any other State agencies with responsibilities for portions of programs primarily administered by the Department of Healthcare and

Family Services.

(5) The Offices of the several United States Attorneys in Illinois.

(6) The several State's Attorneys.

(7) The offices of the Centers for Medicare and Medicaid Services that administer the Medicare and Medicaid integrity programs.

The Inspector General shall meet on a regular basis with these entities to share information regarding possible misconduct by any persons or entities involved with the public aid programs administered by the Department of Healthcare and Family Services.

(e) All investigations conducted by the Inspector General shall be conducted in a manner that ensures the preservation of evidence for use in criminal prosecutions. If the Inspector General determines that a possible criminal act relating to fraud in the provision or administration of the medical assistance program has been committed, the Inspector General shall immediately notify the Medicaid Fraud Control Unit. If the Inspector General determines that a possible criminal act has been committed within the jurisdiction of the Office, the Inspector General may request the special expertise of the Department of State Police. The Inspector General may present for prosecution the findings of any criminal investigation to the Office of the Attorney General, the Offices of the several United States Attorneys in Illinois or the several State's

Attorneys.

(f) To carry out his or her duties as described in this Section, the Inspector General and his or her designees shall have the power to compel by subpoena the attendance and testimony of witnesses and the production of books, electronic records and papers as directly related to public assistance programs administered by the Department of Healthcare and Family Services or the Department of Human Services (as successor to the Department of Public Aid). No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the Medical Assistance Program.

(g) The Inspector General shall report all convictions, terminations, and suspensions taken against vendors, contractors and medical providers to the Department of Healthcare and Family Services and to any agency responsible for licensing or regulating those persons or entities.

(h) The Inspector General shall make annual reports, findings, and recommendations regarding the Office's investigations into reports of fraud, waste, abuse, mismanagement, or misconduct relating to any ~~public aid~~ programs administered by the Department of Healthcare and Family Services or the Department of Human Services (as successor to the Department of Public Aid) to the General Assembly and the Governor. These reports shall include, but not be limited to, the following information:

(1) Aggregate provider billing and payment information, including the number of providers at various Medicaid earning levels.

(2) The number of audits of the medical assistance program and the dollar savings resulting from those audits.

(3) The number of prescriptions rejected annually under the Department of Healthcare and Family Services' Refill Too Soon program and the dollar savings resulting from that program.

(4) Provider sanctions, in the aggregate, including terminations and suspensions.

(5) A detailed summary of the investigations undertaken in the previous fiscal year. These summaries shall comply with all laws and rules regarding maintaining confidentiality in the public aid programs.

(i) Nothing in this Section shall limit investigations by the Department of Healthcare and Family Services or the Department of Human Services that may otherwise be required by law or that may be necessary in their capacity as the central administrative authorities responsible for administration of their agency's ~~public aid~~ programs in this State.

(j) The Inspector General may issue shields or other distinctive identification to his or her employees not exercising the powers of a peace officer if the Inspector General determines that a shield or distinctive identification is needed by an employee to carry out his or her

responsibilities.

(Source: P.A. 95-331, eff. 8-21-07; 96-555, eff. 8-18-09; 96-1316, eff. 1-1-11.)

(305 ILCS 5/14-8) (from Ch. 23, par. 14-8)

Sec. 14-8. Disbursements to Hospitals.

(a) For inpatient hospital services rendered on and after September 1, 1991, the Illinois Department shall reimburse hospitals for inpatient services at an inpatient payment rate calculated for each hospital based upon the Medicare Prospective Payment System as set forth in Sections 1886(b), (d), (g), and (h) of the federal Social Security Act, and the regulations, policies, and procedures promulgated thereunder, except as modified by this Section. Payment rates for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1991. Payment rates for inpatient hospital services rendered on or after October 1, 1992 and on or before March 31, 1994 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1992. Payment rates for inpatient hospital services rendered on or after April 1, 1994 shall be calculated using the Medicare Prospective Payment rates (including the Medicare grouping methodology and weighting factors as adjusted pursuant to paragraph (1) of this subsection) in effect 90 days prior to the date of admission.

For services rendered on or after July 1, 1995, the reimbursement methodology implemented under this subsection shall not include those costs referred to in Sections 1886(d)(5)(B) and 1886(h) of the Social Security Act. The additional payment amounts required under Section 1886(d)(5)(F) of the Social Security Act, for hospitals serving a disproportionate share of low-income or indigent patients, are not required under this Section. For hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated for each hospital that were in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education.

(1) The weighting factors established under Section 1886(d)(4) of the Social Security Act shall not be used in the reimbursement system established under this Section. Rather, the Illinois Department shall establish by rule Medicaid weighting factors to be used in the reimbursement system established under this Section.

(2) The Illinois Department shall define by rule those hospitals or distinct parts of hospitals that shall be exempt from the reimbursement system established under this Section. In defining such hospitals, the Illinois Department shall take into consideration those hospitals exempt from the Medicare Prospective Payment System as of

September 1, 1991. For hospitals defined as exempt under this subsection, the Illinois Department shall by rule establish a reimbursement system for payment of inpatient hospital services rendered on and after September 1, 1991. For all hospitals that are children's hospitals as defined in Section 5-5.02 of this Code, the reimbursement methodology shall, through June 30, 1992, net of all applicable fees, at least equal each children's hospital 1990 ICARE payment rates, indexed to the current year by application of the DRI hospital cost index from 1989 to the year in which payments are made. Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services) for hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education. For inpatient hospital services provided on or after August 1, 1998, the Illinois Department may establish by rule a means of adjusting the rates of children's

hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), that did not meet that definition on June 30, 1995, in order for the inpatient hospital rates of such hospitals to take into account the average inpatient hospital rates of those children's hospitals that did meet the definition of children's hospitals on June 30, 1995.

(3) (Blank)

(4) Notwithstanding any other provision of this Section, hospitals that on August 31, 1991, have a contract with the Illinois Department under Section 3-4 of the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care.

(5) In addition to any payments made under this subsection (a), the Illinois Department shall make the adjustment payments required by Section 5-5.02 of this Code; provided, that in the case of any hospital reimbursed under a per case methodology, the Illinois Department shall add an amount equal to the product of the hospital's average length of stay, less one day, multiplied by 20, for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992.

(b) (Blank)

(b-5) Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Illinois

Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services), for outpatient services rendered on or after July 1, 1995 and before July 1, 1998 the Illinois Department shall reimburse children's hospitals, as defined in the Illinois Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, less that portion of such rates attributed by the Illinois Department to the outpatient indigent volume adjustment and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portions of such rates attributed by the Illinois Department to the cost of medical education and attributed by the Illinois Department to the outpatient indigent volume adjustment. For outpatient services provided on or after July 1, 1998, reimbursement rates shall be established by rule.

(c) In addition to any other payments under this Code, the Illinois Department shall develop a hospital disproportionate share reimbursement methodology that, effective July 1, 1991, through September 30, 1992, shall reimburse hospitals sufficiently to expend the fee monies described in subsection (b) of Section 14-3 of this Code and the federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois Department as required by this subsection (c) and Section 14-2 that are attributable to fee monies deposited in the Fund, less amounts applied to adjustment payments under Section 5-5.02.

(d) Critical Care Access Payments.

(1) In addition to any other payments made under this Code, the Illinois Department shall develop a reimbursement methodology that shall reimburse Critical Care Access Hospitals for the specialized services that qualify them as Critical Care Access Hospitals. No adjustment payments shall be made under this subsection on or after July 1, 1995.

(2) "Critical Care Access Hospitals" includes, but is not limited to, hospitals that meet at least one of the following criteria:

(A) Hospitals located outside of a metropolitan statistical area that are designated as Level II Perinatal Centers and that provide a disproportionate share of perinatal services to recipients; or

(B) Hospitals that are designated as Level I Trauma Centers (adult or pediatric) and certain Level II Trauma Centers as determined by the Illinois Department; or

(C) Hospitals located outside of a metropolitan statistical area and that provide a disproportionate share of obstetrical services to recipients.

(e) Inpatient high volume adjustment. For hospital inpatient services, effective with rate periods beginning on or after October 1, 1993, in addition to rates paid for inpatient services by the Illinois Department, the Illinois Department

shall make adjustment payments for inpatient services furnished by Medicaid high volume hospitals. The Illinois Department shall establish by rule criteria for qualifying as a Medicaid high volume hospital and shall establish by rule a reimbursement methodology for calculating these adjustment payments to Medicaid high volume hospitals. No adjustment payment shall be made under this subsection for services rendered on or after July 1, 1995.

(f) The Illinois Department shall modify its current rules governing adjustment payments for targeted access, critical care access, and uncompensated care to classify those adjustment payments as not being payments to disproportionate share hospitals under Title XIX of the federal Social Security Act. Rules adopted under this subsection shall not be effective with respect to services rendered on or after July 1, 1995. The Illinois Department has no obligation to adopt or implement any rules or make any payments under this subsection for services rendered on or after July 1, 1995.

(f-5) The State recognizes that adjustment payments to hospitals providing certain services or incurring certain costs may be necessary to assure that recipients of medical assistance have adequate access to necessary medical services. These adjustments include payments for teaching costs and uncompensated care, trauma center payments, rehabilitation hospital payments, perinatal center payments, obstetrical care payments, targeted access payments, Medicaid high volume

payments, and outpatient indigent volume payments. On or before April 1, 1995, the Illinois Department shall issue recommendations regarding (i) reimbursement mechanisms or adjustment payments to reflect these costs and services, including methods by which the payments may be calculated and the method by which the payments may be financed, and (ii) reimbursement mechanisms or adjustment payments to reflect costs and services of federally qualified health centers with respect to recipients of medical assistance.

(g) If one or more hospitals file suit in any court challenging any part of this Article XIV, payments to hospitals under this Article XIV shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the court.

(h) Payments under the disbursement methodology described in this Section are subject to approval by the federal government in an appropriate State plan amendment.

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

(j) Hospital Residing Long Term Care Services. In addition to any other payments made under this Code, the Illinois Department may by rule establish criteria and develop methodologies for payments to hospitals for Hospital Residing Long Term Care Services.

(k) Critical Access Hospital outpatient payments. In addition to any other payments authorized under this Code, the Illinois Department shall reimburse critical access hospitals, as designated by the Illinois Department of Public Health in accordance with 42 CFR 485, Subpart F, for outpatient services at an amount that is no less than the cost of providing such services, based on Medicare cost principles. Payments under this subsection shall be subject to appropriation.

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

(Source: P.A. 96-1382, eff. 1-1-11.)

(305 ILCS 5/14-11 new)

Sec. 14-11. Hospital payment reform.

(a) The Department may, by rule, implement the All Patient Refined Diagnosis Related Groups (APR-DRG) payment system for inpatient services provided on or after July 1, 2013, in a manner consistent with the actions authorized in this Section.

(b) On or before October 1, 2012 and through June 30, 2013, the Department shall begin testing the APR-DRG system. During the testing period the Department shall process and price inpatient services using the APR-DRG system; however, actual payments for those inpatient services shall be made using the

current reimbursement system. During the testing period, the Department, in collaboration with the statewide representative of hospitals, shall provide information and technical assistance to hospitals to encourage and facilitate their transition to the APR-DRG system.

(c) The Department may, by rule, implement the Enhanced Ambulatory Procedure Grouping (EAPG) system for outpatient services provided on or after January 1, 2014, in a manner consistent with the actions authorized in this Section. On or before January 1, 2013 and through December 31, 2013, the Department shall begin testing the EAPG system. During the testing period the Department shall process and price outpatient services using the EAPG system; however, actual payments for those outpatient services shall be made using the current reimbursement system. During the testing period, the Department, in collaboration with the statewide representative of hospitals, shall provide information and technical assistance to hospitals to encourage and facilitate their transition to the EAPG system.

(d) The Department in consultation with the current hospital technical advisory group shall review the test claims for inpatient and outpatient services at least monthly, including the estimated impact on hospitals, and, in developing the rules, policies, and procedures to implement the new payment systems, shall consider at least the following issues:

(1) The use of national relative weights provided by

the vendor of the APR-DRG system, adjusted to reflect characteristics of the Illinois Medical Assistance population.

(2) An updated outlier payment methodology based on current data and consistent with the APR-DRG system.

(3) The use of policy adjusters to enhance payments to hospitals treating a high percentage of individuals covered by the Medical Assistance program and uninsured patients.

(4) Reimbursement for inpatient specialty services such as psychiatric, rehabilitation, and long-term acute care using updated per diem rates that account for service acuity.

(5) The creation of one or more transition funding pools to preserve access to care and to ensure financial stability as hospitals transition to the new payment system.

(6) Whether, beginning July 1, 2014, some of the static adjustment payments financed by General Revenue funds should be used as part of the base payment system, including as policy adjusters to recognize the additional costs of certain services, such as pediatric or neonatal, or providers, such as trauma centers, Critical Access Hospitals, or high Medicaid hospitals, or for services to uninsured patients.

(e) The Department shall provide the association

representing the majority of hospitals in Illinois, as the statewide representative of the hospital community, with a monthly file of claims adjudicated under the test system for the purpose of review and analysis as part of the collaboration between the State and the hospital community. The file shall consist of a de-identified extract compliant with the Health Insurance Portability and Accountability Act (HIPAA).

(f) The current hospital technical advisory group shall make recommendations for changes during the testing period and recommendations for changes prior to the effective dates of the new payment systems. The Department shall draft administrative rules to implement the new payment systems and provide them to the technical advisory group at least 90 days prior to the proposed effective dates of the new payment systems.

(g) The payments to hospitals financed by the current hospital assessment, authorized under Article V-A of this Code, are scheduled to sunset on June 30, 2014. The continuation of or revisions to the hospital assessment program shall take into consideration the impact on hospitals and access to care as a result of the changes to the hospital payment system.

(h) Beginning July 1, 2014, the Department may transition current General Revenue funded supplemental payments into the claims based system over a period of no less than 2 years from the implementation date of the new payment systems and no more than 4 years from the implementation date of the new payment systems, provided however that the Department may adopt, by

rule, supplemental payments to help ensure access to care in a geographic area or to help ensure access to specialty services. For any supplemental payments that are adopted that are based on historic data, the data shall be no older than 3 years and the supplemental payment shall be effective for no longer than 2 years before requiring the data to be updated.

(i) Any payments authorized under 89 Illinois Administrative Code 148 set to expire in State fiscal year 2012 and that were paid out to hospitals in State fiscal year 2012, shall remain in effect as long as the assessment imposed by Section 5A-2 is in effect.

(j) Subsections (a) and (c) of this Section shall remain operative unless the Auditor General has certified that: (i) the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-20 of the Illinois State Auditing Act; or (ii) the Department has failed to comply with the reporting requirements of Section 2-20 of the Illinois State Auditing Act.

(k) Subsections (a) and (c) of this Section shall not be operative until final federal approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and implementation of all of the payments and assessments in Article V-A in its form as of the effective date of this amendatory Act of the 97th General Assembly or as it may be amended.

(305 ILCS 5/15-1) (from Ch. 23, par. 15-1)

Sec. 15-1. Definitions. As used in this Article, unless the context requires otherwise:

(a) (Blank). ~~"Base amount" means $108,800,000 multiplied by a fraction, the numerator of which is the number of days represented by the payments in question and the denominator of which is 365.~~

(a-5) "County provider" means a health care provider that is, or is operated by, a county with a population greater than 3,000,000.

(b) "Fund" means the County Provider Trust Fund.

(c) "Hospital" or "County hospital" means a hospital, as defined in Section 14-1 of this Code, which is a county hospital located in a county of over 3,000,000 population.

(Source: P.A. 87-13; 88-85; 88-554, eff. 7-26-94.)

(305 ILCS 5/15-2) (from Ch. 23, par. 15-2)

Sec. 15-2. County Provider Trust Fund.

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

(b) The Fund is created solely for the purposes of receiving, investing, and distributing monies in accordance with this Article XV. The Fund shall consist of:

(1) All monies collected or received by the Illinois Department under Section 15-3 of this Code;

(2) All federal financial participation monies received by the Illinois Department pursuant to Title XIX of the Social Security Act, 42 U.S.C. 1396b, attributable to eligible expenditures made by the Illinois Department pursuant to Section 15-5 of this Code;

(3) All federal moneys received by the Illinois Department pursuant to Title XXI of the Social Security Act attributable to eligible expenditures made by the Illinois Department pursuant to Section 15-5 of this Code; and

(4) All other monies received by the Fund from any source, including interest thereon.

(c) Disbursements from the Fund shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department and shall be made only:

(1) For hospital inpatient care, hospital outpatient care, care provided by other outpatient facilities operated by a county, and disproportionate share hospital adjustment payments made under Title XIX of the Social Security Act and Article V of this Code as required by Section 15-5 of this Code;

(1.5) For services provided <u>or purchased</u> by county providers pursuant to Section 5-11 of this Code;

(2) For the reimbursement of administrative expenses

incurred by county providers on behalf of the Illinois Department as permitted by Section 15-4 of this Code;

(3) For the reimbursement of monies received by the Fund through error or mistake;

(4) For the payment of administrative expenses necessarily incurred by the Illinois Department or its agent in performing the activities required by this Article XV;

(5) For the payment of any amounts that are reimbursable to the federal government, attributable solely to the Fund, and required to be paid by State warrant; and

(6) For hospital inpatient care, hospital outpatient care, care provided by other outpatient facilities operated by a county, and disproportionate share hospital adjustment payments made under Title XXI of the Social Security Act, pursuant to Section 15-5 of this Code.

(7) For medical care and related services provided pursuant to a contract with a county.

(Source: P.A. 95-859, eff. 8-19-08.)

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

Sec. 15-5. Disbursements from the Fund.

(a) The monies in the Fund shall be disbursed only as provided in Section 15-2 of this Code and as follows:

(1) To the extent that such costs are reimbursable

under federal law, to pay the county hospitals' inpatient reimbursement rates based on actual costs incurred, trended forward annually by an inflation index.

(2) To the extent that such costs are reimbursable under federal law, to pay county hospitals and county operated outpatient facilities for outpatient services based on a federally approved methodology to cover the maximum allowable costs.

(3) To pay the county hospitals disproportionate share hospital adjustment payments as may be specified in the Illinois Title XIX State plan.

(3.5) To pay county providers for services provided or purchased pursuant to Section 5-11 of this Code.

(4) To reimburse the county providers for expenses contractually assumed pursuant to Section 15-4 of this Code.

(5) To pay the Illinois Department its necessary administrative expenses relative to the Fund and other amounts agreed to, if any, by the county providers in the agreement provided for in subsection (c).

(6) To pay the county providers any other amount due according to a federally approved State plan, including but not limited to payments made under the provisions of Section 701(d)(3)(B) of the federal Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Intergovernmental transfers supporting payments under this

paragraph (6) shall not be subject to the computation described in subsection (a) of Section 15-3 of this Code, but shall be computed as the difference between the total of such payments made by the Illinois Department to county providers less any amount of federal financial participation due the Illinois Department under Titles XIX and XXI of the Social Security Act as a result of such payments to county providers.

(b) The Illinois Department shall promptly seek all appropriate amendments to the Illinois Title XIX State Plan to maximize reimbursement, including disproportionate share hospital adjustment payments, to the county providers.

(c) (Blank).

(d) The payments provided for herein are intended to cover services rendered on and after July 1, 1991, and any agreement executed between a qualifying county and the Illinois Department pursuant to this Section may relate back to that date, provided the Illinois Department obtains federal approval. Any changes in payment rates resulting from the provisions of Article 3 of this amendatory Act of 1992 are intended to apply to services rendered on or after October 1, 1992, and any agreement executed between a qualifying county and the Illinois Department pursuant to this Section may be effective as of that date.

(e) If one or more hospitals file suit in any court challenging any part of this Article XV, payments to hospitals

from the Fund under this Article XV shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement and may be disbursed under any order of the court.

(f) All payments under this Section are contingent upon federal approval of changes to the Title XIX State plan, if that approval is required.

(Source: P.A. 95-859, eff. 8-19-08.)

(305 ILCS 5/15-11)

Sec. 15-11. Uses of State funds.

(a) At any point, if State revenues referenced in subsection (b) or (c) of Section 15-10 or additional State grants are disbursed to the Cook County Health and Hospitals System, all funds may be used only for the following:

(1) medical services provided at hospitals or clinics owned and operated by the Cook County Health and Hospitals System ~~Bureau of Health Services~~; ~~or~~

(2) information technology to enhance billing capabilities for medical claiming and reimbursement; or ~~.~~

(3) services purchased by county providers pursuant to Section 5-11 of this Code.

(b) State funds may not be used for the following:

(1) non-clinical services, except services that may be required by accreditation bodies or State or federal

regulatory or licensing authorities;

(2) non-clinical support staff, except as pursuant to paragraph (1) of this subsection; or

(3) capital improvements, other than investments in medical technology, except for capital improvements that may be required by accreditation bodies or State or federal regulatory or licensing authorities.

(Source: P.A. 95-859, eff. 8-19-08.)

Section 85. The Pediatric Palliative Care Act is amended by adding Section 3 as follows:

(305 ILCS 60/3 new)

Sec. 3. Act inoperative. Notwithstanding any other provision of law, this Act is inoperative on and after July 1, 2012.

(305 ILCS 5/5-5.4a rep.)

(305 ILCS 5/5-5.4c rep.)

(305 ILCS 5/12-4.36 rep.)

Section 88. The Illinois Public Aid Code is amended by repealing Sections 5-5.4a, 5-5.4c, and 12-4.36.

Section 90. The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is amended by changing the title of the Act and Sections 1, 1.5,

2, 3.05a, 3.10, 4, 4.05, 5, 6, 7, 8, 9, 12, and 13 as follows:

(320 ILCS 25/Act title)

An Act in relation to the payment of grants to enable the elderly and the disabled to acquire or retain private housing ~~and to acquire prescription drugs~~.

(320 ILCS 25/1) (from Ch. 67 1/2, par. 401)

Sec. 1. Short title; common name. This Article shall be known and may be cited as the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act. Common references to the "Circuit Breaker Act" mean this Article. As used in this Article, "this Act" means this Article.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/1.5)

Sec. 1.5. Implementation of Executive Order No. 3 of 2004; termination of the Illinois Senior Citizens and Disabled Persons Pharmaceutical Assistance Program. Executive Order No. 3 of 2004, in part, provided for the transfer of the programs under this Act from the Department of Revenue to the Department on Aging and the Department of Healthcare and Family Services. It is the purpose of this amendatory Act of the 96th General Assembly to conform this Act and certain related provisions of other statutes to that Executive Order. This amendatory Act of

the 96th General Assembly also makes other substantive changes to this Act.

It is the purpose of this amendatory Act of the 97th General Assembly to terminate the Illinois Senior Citizens and Disabled Persons Pharmaceutical Assistance Program on July 1, 2012.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/2) (from Ch. 67 1/2, par. 402)

Sec. 2. Purpose. The purpose of this Act is to provide incentives to the senior citizens and disabled persons of this State to acquire and retain private housing of their choice and at the same time to relieve those citizens from the burdens of extraordinary property taxes ~~and rising drug costs~~ against their increasingly restricted earning power, and thereby to reduce the requirements for public housing in this State.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/3.05a)

Sec. 3.05a. Additional resident. "Additional resident" means a person who (i) is living in the same residence with a claimant for the claim year and at the time of filing the claim, (ii) is not the spouse of the claimant, (iii) does not file a separate claim under this Act for the same period, and (iv) receives more than half of his or her total financial support for that claim year from the household. Prior to July

1, 2012, an ~~An~~ additional resident who meets qualifications may receive pharmaceutical assistance based on a claimant's application.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/3.10) (from Ch. 67 1/2, par. 403.10)

Sec. 3.10. Regulations. "Regulations" includes both rules promulgated and forms prescribed by the applicable Department. In this Act, references to the rules of the Department on Aging or the Department of Healthcare and Family Services, in effect prior to July 1, 2012, shall be deemed to include, in appropriate cases, the corresponding rules adopted by the Department of Revenue, to the extent that those rules continue in force under Executive Order No. 3 of 2004.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/4) (from Ch. 67 1/2, par. 404)

Sec. 4. Amount of Grant.

(a) In general. Any individual 65 years or older or any individual who will become 65 years old during the calendar year in which a claim is filed, and any surviving spouse of such a claimant, who at the time of death received or was entitled to receive a grant pursuant to this Section, which surviving spouse will become 65 years of age within the 24 months immediately following the death of such claimant and which surviving spouse but for his or her age is otherwise

qualified to receive a grant pursuant to this Section, and any disabled person whose annual household income is less than the income eligibility limitation, as defined in subsection (a-5) and whose household is liable for payment of property taxes accrued or has paid rent constituting property taxes accrued and is domiciled in this State at the time he or she files his or her claim is entitled to claim a grant under this Act. With respect to claims filed by individuals who will become 65 years old during the calendar year in which a claim is filed, the amount of any grant to which that household is entitled shall be an amount equal to 1/12 of the amount to which the claimant would otherwise be entitled as provided in this Section, multiplied by the number of months in which the claimant was 65 in the calendar year in which the claim is filed.

(a-5) Income eligibility limitation. For purposes of this Section, "income eligibility limitation" means an amount for grant years 2008 and thereafter:

(1) less than $22,218 for a household containing one person;

(2) less than $29,480 for a household containing 2 persons; or

(3) less than $36,740 for a household containing 3 or more persons.

For 2009 claim year applications submitted during calendar year 2010, a household must have annual household income of less than $27,610 for a household containing one person; less

than $36,635 for a household containing 2 persons; or less than $45,657 for a household containing 3 or more persons.

The Department on Aging may adopt rules such that on January 1, 2011, and thereafter, the foregoing household income eligibility limits may be changed to reflect the annual cost of living adjustment in Social Security and Supplemental Security Income benefits that are applicable to the year for which those benefits are being reported as income on an application.

If a person files as a surviving spouse, then only his or her income shall be counted in determining his or her household income.

(b) Limitation. Except as otherwise provided in subsections (a) and (f) of this Section, the maximum amount of grant which a claimant is entitled to claim is the amount by which the property taxes accrued which were paid or payable during the last preceding tax year or rent constituting property taxes accrued upon the claimant's residence for the last preceding taxable year exceeds 3 1/2% of the claimant's household income for that year but in no event is the grant to exceed (i) $700 less 4.5% of household income for that year for those with a household income of $14,000 or less or (ii) $70 if household income for that year is more than $14,000.

(c) Public aid recipients. If household income in one or more months during a year includes cash assistance in excess of $55 per month from the Department of Healthcare and Family Services or the Department of Human Services (acting as

successor to the Department of Public Aid under the Department of Human Services Act) which was determined under regulations of that Department on a measure of need that included an allowance for actual rent or property taxes paid by the recipient of that assistance, the amount of grant to which that household is entitled, except as otherwise provided in subsection (a), shall be the product of (1) the maximum amount computed as specified in subsection (b) of this Section and (2) the ratio of the number of months in which household income did not include such cash assistance over $55 to the number twelve. If household income did not include such cash assistance over $55 for any months during the year, the amount of the grant to which the household is entitled shall be the maximum amount computed as specified in subsection (b) of this Section. For purposes of this paragraph (c), "cash assistance" does not include any amount received under the federal Supplemental Security Income (SSI) program.

(d) Joint ownership. If title to the residence is held jointly by the claimant with a person who is not a member of his or her household, the amount of property taxes accrued used in computing the amount of grant to which he or she is entitled shall be the same percentage of property taxes accrued as is the percentage of ownership held by the claimant in the residence.

(e) More than one residence. If a claimant has occupied more than one residence in the taxable year, he or she may

claim only one residence for any part of a month. In the case of property taxes accrued, he or she shall prorate 1/12 of the total property taxes accrued on his or her residence to each month that he or she owned and occupied that residence; and, in the case of rent constituting property taxes accrued, shall prorate each month's rent payments to the residence actually occupied during that month.

(f) (Blank).

(g) Effective January 1, 2006, there is hereby established a program of pharmaceutical assistance to the aged and disabled, entitled the Illinois Seniors and Disabled Drug Coverage Program, which shall be administered by the Department of Healthcare and Family Services and the Department on Aging in accordance with this subsection, to consist of coverage of specified prescription drugs on behalf of beneficiaries of the program as set forth in this subsection. Notwithstanding any provisions of this Act to the contrary, on and after July 1, 2012, pharmaceutical assistance under this Act shall no longer be provided, and on July 1, 2012 the Illinois Senior Citizens and Disabled Persons Pharmaceutical Assistance Program shall terminate. The following provisions that concern the Illinois Senior Citizens and Disabled Persons Pharmaceutical Assistance Program shall continue to apply on and after July 1, 2012 to the extent necessary to pursue any actions authorized by subsection (d) of Section 9 of this Act with respect to acts which took place prior to July 1, 2012.

To become a beneficiary under the program established under this subsection, a person must:

(1) be (i) 65 years of age or older or (ii) disabled; and

(2) be domiciled in this State; and

(3) enroll with a qualified Medicare Part D Prescription Drug Plan if eligible and apply for all available subsidies under Medicare Part D; and

(4) for the 2006 and 2007 claim years, have a maximum household income of (i) less than $21,218 for a household containing one person, (ii) less than $28,480 for a household containing 2 persons, or (iii) less than $35,740 for a household containing 3 or more persons; and

(5) for the 2008 claim year, have a maximum household income of (i) less than $22,218 for a household containing one person, (ii) $29,480 for a household containing 2 persons, or (iii) $36,740 for a household containing 3 or more persons; and

(6) for 2009 claim year applications submitted during calendar year 2010, have annual household income of less than (i) $27,610 for a household containing one person; (ii) less than $36,635 for a household containing 2 persons; or (iii) less than $45,657 for a household containing 3 or more persons; and

(7) as of September 1, 2011, have a maximum household income at or below 200% of the federal poverty level.

All individuals enrolled as of December 31, 2005, in the pharmaceutical assistance program operated pursuant to subsection (f) of this Section and all individuals enrolled as of December 31, 2005, in the SeniorCare Medicaid waiver program operated pursuant to Section 5-5.12a of the Illinois Public Aid Code shall be automatically enrolled in the program established by this subsection for the first year of operation without the need for further application, except that they must apply for Medicare Part D and the Low Income Subsidy under Medicare Part D. A person enrolled in the pharmaceutical assistance program operated pursuant to subsection (f) of this Section as of December 31, 2005, shall not lose eligibility in future years due only to the fact that they have not reached the age of 65.

To the extent permitted by federal law, the Department may act as an authorized representative of a beneficiary in order to enroll the beneficiary in a Medicare Part D Prescription Drug Plan if the beneficiary has failed to choose a plan and, where possible, to enroll beneficiaries in the low-income subsidy program under Medicare Part D or assist them in enrolling in that program.

Beneficiaries under the program established under this subsection shall be divided into the following 4 eligibility groups:

(A) Eligibility Group 1 shall consist of beneficiaries who are not eligible for Medicare Part D coverage and who are:

(i) disabled and under age 65; or

(ii) age 65 or older, with incomes over 200% of the Federal Poverty Level; or

(iii) age 65 or older, with incomes at or below 200% of the Federal Poverty Level and not eligible for federally funded means-tested benefits due to immigration status.

(B) Eligibility Group 2 shall consist of beneficiaries who are eligible for Medicare Part D coverage.

(C) Eligibility Group 3 shall consist of beneficiaries age 65 or older, with incomes at or below 200% of the Federal Poverty Level, who are not barred from receiving federally funded means-tested benefits due to immigration status and are not eligible for Medicare Part D coverage.

If the State applies and receives federal approval for a waiver under Title XIX of the Social Security Act, persons in Eligibility Group 3 shall continue to receive benefits through the approved waiver, and Eligibility Group 3 may be expanded to include disabled persons under age 65 with incomes under 200% of the Federal Poverty Level who are not eligible for Medicare and who are not barred from receiving federally funded means-tested benefits due to immigration status.

(D) Eligibility Group 4 shall consist of beneficiaries who are otherwise described in Eligibility Group 2 who have a diagnosis of HIV or AIDS.

The program established under this subsection shall cover the cost of covered prescription drugs in excess of the beneficiary cost-sharing amounts set forth in this paragraph that are not covered by Medicare. The Department of Healthcare and Family Services may establish by emergency rule changes in cost-sharing necessary to conform the cost of the program to the amounts appropriated for State fiscal year 2012 and future fiscal years except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 of the Illinois Administrative Procedure Act shall not apply to rules adopted under this subsection (g). The adoption of emergency rules authorized by this subsection (g) shall be deemed to be necessary for the public interest, safety, and welfare.

For purposes of the program established under this subsection, the term "covered prescription drug" has the following meanings:

For Eligibility Group 1, "covered prescription drug" means: (1) any cardiovascular agent or drug; (2) any insulin or other prescription drug used in the treatment of diabetes, including syringe and needles used to administer the insulin; (3) any prescription drug used in the treatment of arthritis; (4) any prescription drug used in the treatment of cancer; (5) any prescription drug used in the treatment of Alzheimer's disease; (6) any prescription drug used in the treatment of Parkinson's disease; (7) any

prescription drug used in the treatment of glaucoma; (8) any prescription drug used in the treatment of lung disease and smoking-related illnesses; (9) any prescription drug used in the treatment of osteoporosis; and (10) any prescription drug used in the treatment of multiple sclerosis. The Department may add additional therapeutic classes by rule. The Department may adopt a preferred drug list within any of the classes of drugs described in items (1) through (10) of this paragraph. The specific drugs or therapeutic classes of covered prescription drugs shall be indicated by rule.

For Eligibility Group 2, "covered prescription drug" means those drugs covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

For Eligibility Group 3, "covered prescription drug" means those drugs covered by the Medical Assistance Program under Article V of the Illinois Public Aid Code.

For Eligibility Group 4, "covered prescription drug" means those drugs covered by the Medicare Part D Prescription Drug Plan in which the beneficiary is enrolled.

Any person otherwise eligible for pharmaceutical assistance under this subsection whose covered drugs are covered by any public program is ineligible for assistance under this subsection to the extent that the cost of those

drugs is covered by the other program.

The Department of Healthcare and Family Services shall establish by rule the methods by which it will provide for the coverage called for in this subsection. Those methods may include direct reimbursement to pharmacies or the payment of a capitated amount to Medicare Part D Prescription Drug Plans.

For a pharmacy to be reimbursed under the program established under this subsection, it must comply with rules adopted by the Department of Healthcare and Family Services regarding coordination of benefits with Medicare Part D Prescription Drug Plans. A pharmacy may not charge a Medicare-enrolled beneficiary of the program established under this subsection more for a covered prescription drug than the appropriate Medicare cost-sharing less any payment from or on behalf of the Department of Healthcare and Family Services.

The Department of Healthcare and Family Services or the Department on Aging, as appropriate, may adopt rules regarding applications, counting of income, proof of Medicare status, mandatory generic policies, and pharmacy reimbursement rates and any other rules necessary for the cost-efficient operation of the program established under this subsection.

(h) A qualified individual is not entitled to duplicate benefits in a coverage period as a result of the changes made by this amendatory Act of the 96th General Assembly.

(Source: P.A. 96-804, eff. 1-1-10; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11.)

(320 ILCS 25/4.05)

Sec. 4.05. Application.

(a) The Department on Aging shall establish the content, required eligibility and identification information, use of social security numbers, and manner of applying for benefits in a simplified format under this Act~~, including claims filed for new or renewed prescription drug benefits~~.

(b) An application may be filed on paper or over the Internet ~~to enable persons to apply separately or for both a property tax relief grant and pharmaceutical assistance on the same application. An application may also enable persons to apply for other State or federal programs that provide medical or pharmaceutical assistance or other benefits, as determined by the Department on Aging in conjunction with the Department of Healthcare and Family Services~~.

(c) Applications must be filed during the time period prescribed by the Department.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/5) (from Ch. 67 1/2, par. 405)

Sec. 5. Procedure.

(a) In general. Claims must be filed after January 1, on forms prescribed by the Department. No claim may be filed more than one year after December 31 of the year for which the claim is filed. ~~The pharmaceutical assistance identification card~~

~~provided for in subsection (f) of Section 4 shall be valid for a period determined by the Department of Healthcare and Family Services.~~

(b) Claim is Personal. The right to file a claim under this Act shall be personal to the claimant and shall not survive his death, but such right may be exercised on behalf of a claimant by his legal guardian or attorney-in-fact. If a claimant dies after having filed a timely claim, the amount thereof shall be disbursed to his surviving spouse or, if no spouse survives, to his surviving dependent minor children in equal parts, provided the spouse or child, as the case may be, resided with the claimant at the time he filed his claim. If at the time of disbursement neither the claimant nor his spouse is surviving, and no dependent minor children of the claimant are surviving the amount of the claim shall escheat to the State.

(c) One claim per household. Only one member of a household may file a claim under this Act in any calendar year; where both members of a household are otherwise entitled to claim a grant under this Act, they must agree as to which of them will file a claim for that year.

(d) (Blank).

(e) Pharmaceutical Assistance Procedures. Prior to July 1, 2012, the ~~The~~ Department of Healthcare and Family Services shall determine eligibility for pharmaceutical assistance using the applicant's current income. The Department shall determine a person's current income in the manner provided by

the Department by rule.

(f) A person may not under any circumstances charge a fee to a claimant under this Act for assistance in completing an application form for a property tax relief grant ~~or pharmaceutical assistance~~ under this Act.

(Source: P.A. 96-491, eff. 8-14-09; 96-804, eff. 1-1-10; 96-1000, eff. 7-2-10.)

(320 ILCS 25/6) (from Ch. 67 1/2, par. 406)

Sec. 6. Administration.

(a) In general. Upon receipt of a timely filed claim, the Department shall determine whether the claimant is a person entitled to a grant under this Act and the amount of grant to which he is entitled under this Act. The Department may require the claimant to furnish reasonable proof of the statements of domicile, household income, rent paid, property taxes accrued and other matters on which entitlement is based, and may withhold payment of a grant until such additional proof is furnished.

(b) Rental determination. If the Department finds that the gross rent used in the computation by a claimant of rent constituting property taxes accrued exceeds the fair rental value for the right to occupy that residence, the Department may determine the fair rental value for that residence and recompute rent constituting property taxes accrued accordingly.

(c) Fraudulent claims. The Department shall deny claims which have been fraudulently prepared or when it finds that the claimant has acquired title to his residence or has paid rent for his residence primarily for the purpose of receiving a grant under this Act.

(d) (Blank). ~~Pharmaceutical Assistance. The Department shall allow all pharmacies licensed under the Pharmacy Practice Act to participate as authorized pharmacies unless they have been removed from that status for cause pursuant to the terms of this Section. The Director of the Department may enter into a written contract with any State agency, instrumentality or political subdivision, or a fiscal intermediary for the purpose of making payments to authorized pharmacies for covered prescription drugs and coordinating the program of pharmaceutical assistance established by this Act with other programs that provide payment for covered prescription drugs. Such agreement shall establish procedures for properly contracting for pharmacy services, validating reimbursement claims, validating compliance of dispensing pharmacists with the contracts for participation required under this Section, validating the reasonable costs of covered prescription drugs, and otherwise providing for the effective administration of this Act.~~

~~The Department shall promulgate rules and regulations to implement and administer the program of pharmaceutical assistance required by this Act, which shall include the~~

~~following:~~

~~(1) Execution of contracts with pharmacies to dispense covered prescription drugs. Such contracts shall stipulate terms and conditions for authorized pharmacies participation and the rights of the State to terminate such participation for breach of such contract or for violation of this Act or related rules and regulations of the Department;~~

~~(2) Establishment of maximum limits on the size of prescriptions, new or refilled, which shall be in amounts sufficient for 34 days, except as otherwise specified by rule for medical or utilization control reasons;~~

~~(3) Establishment of liens upon any and all causes of action which accrue to a beneficiary as a result of injuries for which covered prescription drugs are directly or indirectly required and for which the Director made payment or became liable for under this Act;~~

~~(4) Charge or collection of payments from third parties or private plans of assistance, or from other programs of public assistance for any claim that is properly chargeable under the assignment of benefits executed by beneficiaries as a requirement of eligibility for the pharmaceutical assistance identification card under this Act;~~

~~(4.5) Provision for automatic enrollment of beneficiaries into a Medicare Discount Card program authorized under the federal Medicare Modernization Act of~~

~~2003 (P.L. 108-391) to coordinate coverage including Medicare Transitional Assistance;~~

~~(5) Inspection of appropriate records and audit of participating authorized pharmacies to ensure contract compliance, and to determine any fraudulent transactions or practices under this Act;~~

~~(6) Annual determination of the reasonable costs of covered prescription drugs for which payments are made under this Act, as provided in Section 3.16 (now repealed);~~

~~(7) Payment to pharmacies under this Act in accordance with the State Prompt Payment Act.~~

~~The Department shall annually report to the Governor and the General Assembly by March 1st of each year on the administration of pharmaceutical assistance under this Act. By the effective date of this Act the Department shall determine the reasonable costs of covered prescription drugs in accordance with Section 3.16 of this Act (now repealed).~~

(Source: P.A. 96-328, eff. 8-11-09; 97-333, eff. 8-12-11.)

(320 ILCS 25/7) (from Ch. 67 1/2, par. 407)

Sec. 7. Payment and denial of claims.

(a) In general. The Director shall order the payment from appropriations made for that purpose of grants to claimants under this Act in the amounts to which the Department has determined they are entitled, respectively. If a claim is denied, the Director shall cause written notice of that denial

and the reasons for that denial to be sent to the claimant.

(b) Payment of claims one dollar and under. Where the amount of the grant computed under Section 4 is less than one dollar, the Department shall pay to the claimant one dollar.

(c) Right to appeal. Any person aggrieved by an action or determination of the Department on Aging arising under any of its powers or duties under this Act may request in writing that the Department on Aging reconsider its action or determination, setting out the facts upon which the request is based. The Department on Aging shall consider the request and either modify or affirm its prior action or determination. The Department on Aging may adopt, by rule, procedures for conducting its review under this Section.

~~Any person aggrieved by an action or determination of the Department of Healthcare and Family Services arising under any of its powers or duties under this Act may request in writing that the Department of Healthcare and Family Services reconsider its action or determination, setting out the facts upon which the request is based. The Department of Healthcare and Family Services shall consider the request and either modify or affirm its prior action or determination. The Department of Healthcare and Family Services may adopt, by rule, procedures for conducting its review under this Section.~~

(d) (Blank).

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/8) (from Ch. 67 1/2, par. 408)

Sec. 8. Records. Every claimant of a grant under this Act and, prior to July 1, 2012, every applicant for pharmaceutical assistance under this Act shall keep such records, render such statements, file such forms and comply with such rules and regulations as the Department on Aging may from time to time prescribe. The Department on Aging may by regulations require landlords to furnish to tenants statements as to gross rent or rent constituting property taxes accrued.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/9) (from Ch. 67 1/2, par. 409)

Sec. 9. Fraud; error.

(a) Any person who files a fraudulent claim for a grant under this Act, or who for compensation prepares a claim for a grant and knowingly enters false information on an application for any claimant under this Act, or who fraudulently files multiple applications, or who fraudulently states that a nondisabled person is disabled, or who, prior to July 1, 2012, fraudulently procures pharmaceutical assistance benefits, or who fraudulently uses such assistance to procure covered prescription drugs, or who, on behalf of an authorized pharmacy, files a fraudulent request for payment, is guilty of a Class 4 felony for the first offense and is guilty of a Class 3 felony for each subsequent offense.

(b) (Blank). ~~The Department on Aging and the Department of~~

~~Healthcare and Family Services shall immediately suspend the pharmaceutical assistance benefits of any person suspected of fraudulent procurement or fraudulent use of such assistance, and shall revoke such assistance upon a conviction. A person convicted of fraud under subsection (a) shall be permanently barred from all of the programs established under this Act.~~

(c) The Department on Aging may recover from a claimant any amount paid to that claimant under this Act on account of an erroneous or fraudulent claim, together with 6% interest per year. Amounts recoverable from a claimant by the Department on Aging under this Act may, but need not, be recovered by offsetting the amount owed against any future grant payable to the person under this Act.

The Department of Healthcare and Family Services may recover for acts prior to July 1, 2012 from an authorized pharmacy any amount paid to that pharmacy under the pharmaceutical assistance program on account of an erroneous or fraudulent request for payment under that program, together with 6% interest per year. The Department of Healthcare and Family Services may recover from a person who erroneously or fraudulently obtains benefits under the pharmaceutical assistance program the value of the benefits so obtained, together with 6% interest per year.

(d) A prosecution for a violation of this Section may be commenced at any time within 3 years of the commission of that violation.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/12) (from Ch. 67 1/2, par. 412)

Sec. 12. Regulations - Department on Aging.

(a) Regulations. Notwithstanding any other provision to the contrary, the Department on Aging may adopt rules regarding applications, proof of eligibility, required identification information, use of social security numbers, counting of income, and a method of computing "gross rent" in the case of a claimant living in a nursing or sheltered care home, and any other rules necessary for the cost-efficient operation of the program established under Section 4.

(b) The Department on Aging shall, to the extent of appropriations made for that purpose:

(1) attempt to secure the cooperation of appropriate federal, State and local agencies in securing the names and addresses of persons to whom this Act pertains;

(2) prepare a mailing list of persons eligible for grants under this Act;

(3) secure the cooperation of the Department of Revenue, ~~the Department of Healthcare and Family Services,~~ other State agencies, and local business establishments to facilitate distribution of applications under this Act to those eligible to file claims; and

(4) through use of direct mail, newspaper advertisements and radio and television advertisements,

and all other appropriate means of communication, conduct an on-going public relations program to increase awareness of eligible citizens of the benefits under this Act and the procedures for applying for them.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/13) (from Ch. 67 1/2, par. 413)

Sec. 13. List of persons who have qualified. The Department on Aging shall maintain a list of all persons who have qualified under this Act and shall make the list available to ~~the Department of Healthcare and Family Services,~~ the Department of Public Health, the Secretary of State, municipalities, and public transit authorities upon request.

All information received by a State agency, municipality, or public transit authority under this Section shall be confidential, except for official purposes, and any person who divulges or uses that information in any manner, except in accordance with a proper judicial order, shall be guilty of a Class B misdemeanor.

(Source: P.A. 96-804, eff. 1-1-10.)

(320 ILCS 25/4.1 rep.)

Section 95. The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is amended by repealing Section 4.1.

Section 100. The Sexual Assault Survivors Emergency Treatment Act is amended by changing Section 7 as follows:

(410 ILCS 70/7) (from Ch. 111 1/2, par. 87-7)

Sec. 7. Reimbursement ~~Charges and reimbursement~~.

(a) When any ambulance provider furnishes transportation, hospital provides hospital emergency services and forensic services, hospital or health care professional or laboratory provides follow-up healthcare, or pharmacy dispenses prescribed medications to any sexual assault survivor, as defined by the Department of Healthcare and Family Services, who is neither eligible to receive such services under the Illinois Public Aid Code nor covered as to such services by a policy of insurance, the ambulance provider, hospital, health care professional, pharmacy, or laboratory shall furnish such services to that person without charge and shall be entitled to be reimbursed for ~~its billed charges in~~ providing such services by the Illinois Sexual Assault Emergency Treatment Program under the Department of Healthcare and Family Services~~.~~ ~~Pharmacies shall dispense prescribed medications without charge to the survivor and shall be reimbursed~~ and at the Department of Healthcare and Family Services' ~~Medicaid~~ allowable rates under the Illinois Public Aid Code.

(b) The hospital is responsible for submitting the request for reimbursement for ambulance services, hospital emergency services, and forensic services to the Illinois Sexual Assault

Emergency Treatment Program. Nothing in this Section precludes hospitals from providing follow-up healthcare and receiving reimbursement under this Section.

(c) The health care professional who provides follow-up healthcare and the pharmacy that dispenses prescribed medications to a sexual assault survivor are responsible for submitting the request for reimbursement for follow-up healthcare or pharmacy services to the Illinois Sexual Assault Emergency Treatment Program.

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

(d) The Department of Healthcare and Family Services shall establish standards, rules, and regulations to implement this Section.

(Source: P.A. 95-331, eff. 8-21-07; 95-432, eff. 1-1-08.)

Section 102. The Hemophilia Care Act is amended by changing Section 3 as follows:

(410 ILCS 420/3) (from Ch. 111 1/2, par. 2903)

Sec. 3. The powers and duties of the Department shall include the following:

(1) With the advice and counsel of the Committee, develop standards for determining eligibility for care and treatment under this program. Among other standards developed under this Section, persons suffering from hemophilia must be evaluated in a center properly staffed and equipped for such evaluation, but not operated by the Department.

(2) (Blank).

(3) Extend financial assistance to eligible persons in order that they may obtain blood and blood derivatives for use in hospitals, in medical and dental facilities, or at home. The Department shall extend financial assistance in each fiscal year to each family containing one or more eligible persons in the amount of (a) the family's eligible cost of hemophilia services for that fiscal year, minus (b) one fifth of its available family income for its next preceding taxable year. The Director may extend financial assistance in the case of unusual hardships, according to specific procedures and conditions adopted for this purpose in the rules and regulations promulgated by the Department to implement and administer this Act.

(4) (Blank).

(5) Promulgate rules and regulations with the advice and counsel of the Committee for the implementation and administration of this Act.

<u>On and after July 1, 2012, the Department shall reduce any</u>

rate of reimbursement for services or other payments or alter any methodologies authorized by this Act or the Illinois Public Aid Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e of the Illinois Public Aid Code.

(Source: P.A. 89-507, eff. 7-1-97; 90-587, eff. 7-1-98.)

Section 103. The Renal Disease Treatment Act is amended by changing Section 3 as follows:

(410 ILCS 430/3) (from Ch. 111 1/2, par. 22.33)

Sec. 3. Duties of Departments of Healthcare and Family Services and Public Health.

(A) The Department of Healthcare and Family Services shall:

(a) With the advice of the Renal Disease Advisory Committee, develop standards for determining eligibility for care and treatment under this program. Among other standards so developed under this paragraph, candidates, to be eligible for care and treatment, must be evaluated in a center properly staffed and equipped for such evaluation.

(b) (Blank).

(c) (Blank).

(d) Extend financial assistance to persons suffering from chronic renal diseases in obtaining the medical, surgical, nursing, pharmaceutical, and technical services necessary in caring for such diseases, including the

renting of home dialysis equipment. The Renal Disease Advisory Committee shall recommend to the Department the extent of financial assistance, including the reasonable charges and fees, for:

(1) Treatment in a dialysis facility;

(2) Hospital treatment for dialysis and transplant surgery;

(3) Treatment in a limited care facility;

(4) Home dialysis training; and

(5) Home dialysis.

(e) Assist in equipping dialysis centers.

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

(B) The Department of Public Health shall:

(a) Assist in the development and expansion of programs for the care and treatment of persons suffering from chronic renal diseases, including dialysis and other medical or surgical procedures and techniques that will have a lifesaving effect in the care and treatment of persons suffering from these diseases.

(b) Assist in the development of programs for the prevention of chronic renal diseases.

(c) Institute and carry on an educational program among physicians, hospitals, public health departments, and the public concerning chronic renal diseases, including the dissemination of information and the conducting of educational programs concerning the prevention of chronic renal diseases and the methods for the care and treatment of persons suffering from these diseases.

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

Section 104. The Code of Civil Procedure is amended by changing Section 5-105 as follows:

(735 ILCS 5/5-105) (from Ch. 110, par. 5-105)

Sec. 5-105. Leave to sue or defend as an indigent person.

(a) As used in this Section:

(1) "Fees, costs, and charges" means payments imposed on a party in connection with the prosecution or defense of a civil action, including, but not limited to: filing fees; appearance fees; fees for service of process and other papers served either within or outside this State, including service by publication pursuant to Section 2-206 of this Code and publication of necessary legal notices; motion fees; jury demand fees; charges for participation in, or attendance at, any mandatory process or procedure including, but not limited to, conciliation, mediation, arbitration, counseling, evaluation, "Children First",

"Focus on Children" or similar programs; fees for supplementary proceedings; charges for translation services; guardian ad litem fees; charges for certified copies of court documents; and all other processes and procedures deemed by the court to be necessary to commence, prosecute, defend, or enforce relief in a civil action.

(2) "Indigent person" means any person who meets one or more of the following criteria:

(i) He or she is receiving assistance under one or more of the following public benefits programs: Supplemental Security Income (SSI), Aid to the Aged, Blind and Disabled (AABD), Temporary Assistance for Needy Families (TANF), Food Stamps, General Assistance, ~~State~~ Transitional Assistance, or State Children and Family Assistance.

(ii) His or her available income is 125% or less of the current poverty level as established by the United States Department of Health and Human Services, unless the applicant's assets that are not exempt under Part 9 or 10 of Article XII of this Code are of a nature and value that the court determines that the applicant is able to pay the fees, costs, and charges.

(iii) He or she is, in the discretion of the court, unable to proceed in an action without payment of fees, costs, and charges and whose payment of those fees, costs, and charges would result in substantial

hardship to the person or his or her family.

(iv) He or she is an indigent person pursuant to Section 5-105.5 of this Code.

(b) On the application of any person, before, or after the commencement of an action, a court, on finding that the applicant is an indigent person, shall grant the applicant leave to sue or defend the action without payment of the fees, costs, and charges of the action.

(c) An application for leave to sue or defend an action as an indigent person shall be in writing and supported by the affidavit of the applicant or, if the applicant is a minor or an incompetent adult, by the affidavit of another person having knowledge of the facts. The contents of the affidavit shall be established by Supreme Court Rule. The court shall provide, through the office of the clerk of the court, simplified forms consistent with the requirements of this Section and applicable Supreme Court Rules to any person seeking to sue or defend an action who indicates an inability to pay the fees, costs, and charges of the action. The application and supporting affidavit may be incorporated into one simplified form. The clerk of the court shall post in a conspicuous place in the courthouse a notice no smaller than 8.5 x 11 inches, using no smaller than 30-point typeface printed in English and in Spanish, advising the public that they may ask the court for permission to sue or defend a civil action without payment of fees, costs, and charges. The notice shall be substantially as follows:

"If you are unable to pay the fees, costs, and charges of an action you may ask the court to allow you to proceed without paying them. Ask the clerk of the court for forms."

(d) The court shall rule on applications under this Section in a timely manner based on information contained in the application unless the court, in its discretion, requires the applicant to personally appear to explain or clarify information contained in the application. If the court finds that the applicant is an indigent person, the court shall enter an order permitting the applicant to sue or defend without payment of fees, costs, or charges. If the application is denied, the court shall enter an order to that effect stating the specific reasons for the denial. The clerk of the court shall promptly mail or deliver a copy of the order to the applicant.

(e) The clerk of the court shall not refuse to accept and file any complaint, appearance, or other paper presented by the applicant if accompanied by an application to sue or defend in forma pauperis, and those papers shall be considered filed on the date the application is presented. If the application is denied, the order shall state a date certain by which the necessary fees, costs, and charges must be paid. The court, for good cause shown, may allow an applicant whose application is denied to defer payment of fees, costs, and charges, make installment payments, or make payment upon reasonable terms and conditions stated in the order. The court may dismiss the

claims or defenses of any party failing to pay the fees, costs, or charges within the time and in the manner ordered by the court. A determination concerning an application to sue or defend in forma pauperis shall not be construed as a ruling on the merits.

(f) The court may order an indigent person to pay all or a portion of the fees, costs, or charges waived pursuant to this Section out of moneys recovered by the indigent person pursuant to a judgment or settlement resulting from the civil action. However, nothing in ~~is~~ this Section shall be construed to limit the authority of a court to order another party to the action to pay the fees, costs, or charges of the action.

(g) A court, in its discretion, may appoint counsel to represent an indigent person, and that counsel shall perform his or her duties without fees, charges, or reward.

(h) Nothing in this Section shall be construed to affect the right of a party to sue or defend an action in forma pauperis without the payment of fees, costs, or charges, or the right of a party to court-appointed counsel, as authorized by any other provision of law or by the rules of the Illinois Supreme Court.

(i) The provisions of this Section are severable under Section 1.31 of the Statute on Statutes.

(Source: P.A. 91-621, eff. 8-19-99; revised 11-21-11.)

Section 105. The Unemployment Insurance Act is amended by

changing Sections 1400.2, 1402, 1404, 1405, 1801.1, and 1900 as follows:

(820 ILCS 405/1400.2)

Sec. 1400.2. Annual reporting and paying; household workers. This Section applies to an employer who solely employs one or more household workers with respect to whom the employer files federal unemployment taxes as part of his or her federal income tax return, or could file federal unemployment taxes as part of his or her federal income tax return if the worker or workers were providing services in employment for purposes of the federal unemployment tax. For purposes of this Section, "household worker" has the meaning ascribed to it for purposes of Section 3510 of the federal Internal Revenue Code. If an employer to whom this Section applies notifies the Director, in writing, that he or she wishes to pay his or her contributions for each quarter and submit his or her wage ~~and contribution~~ reports for each month or quarter, as the case may be, on an annual basis, then the due date for filing the reports and paying the contributions shall be April 15 of the calendar year immediately following the close of the months or quarters to which the reports and quarters to which the contributions apply, except that the Director may, by rule, establish a different due date for good cause.

(Source: P.A. 94-723, eff. 1-19-06.)

(820 ILCS 405/1402) (from Ch. 48, par. 552)

Sec. 1402. Penalties.

A. If any employer fails, within the time prescribed in this Act as amended and in effect on October 5, 1980, and the regulations of the Director, to file a report of wages paid to each of his workers, or to file a sufficient report of such wages after having been notified by the Director to do so, for any period which begins prior to January 1, 1982, he shall pay to the Director as a penalty a sum determined in accordance with the provisions of this Act as amended and in effect on October 5, 1980.

B. Except as otherwise provided in this Section, any employer who fails to file a report of wages paid to each of his workers for any period which begins on or after January 1, 1982, within the time prescribed by the provisions of this Act and the regulations of the Director, or, if the Director pursuant to such regulations extends the time for filing the report, fails to file it within the extended time, shall, in addition to any sum otherwise payable by him under the provisions of this Act, pay to the Director as a penalty a sum equal to the lesser of (1) $5 for each $10,000 or fraction thereof of the total wages for insured work paid by him during the period or (2) $2,500, for each month or part thereof of such failure to file the report. With respect to an employer who has elected to file reports of wages on an annual basis pursuant to Section 1400.2, in assessing penalties for the

failure to submit all reports by the due date established pursuant to that Section, the 30-day period immediately following the due date shall be considered as one month.

If the Director deems an employer's report of wages paid to each of his workers for any period which begins on or after January 1, 1982, insufficient, he shall notify the employer to file a sufficient report. If the employer fails to file such sufficient report within 30 days after the mailing of the notice to him, he shall, in addition to any sum otherwise payable by him under the provisions of this Act, pay to the Director as a penalty a sum determined in accordance with the provisions of the first paragraph of this subsection, for each month or part thereof of such failure to file such sufficient report after the date of the notice.

For wages paid in calendar years prior to 1988, the penalty or penalties which accrue under the two foregoing paragraphs with respect to a report for any period shall not be less than $100, and shall not exceed the lesser of (1) $10 for each $10,000 or fraction thereof of the total wages for insured work paid during the period or (2) $5,000. For wages paid in calendar years after 1987, the penalty or penalties which accrue under the 2 foregoing paragraphs with respect to a report for any period shall not be less than $50, and shall not exceed the lesser of (1) $10 for each $10,000 or fraction of the total wages for insured work paid during the period or (2) $5,000. With respect to an employer who has elected to file

reports of wages on an annual basis pursuant to Section 1400.2, for purposes of calculating the minimum penalty prescribed by this Section for failure to file the reports on a timely basis, a calendar year shall constitute a single period. For reports of wages paid after 1986, the Director shall not, however, impose a penalty pursuant to either of the two foregoing paragraphs on any employer who can prove within 30 working days after the mailing of a notice of his failure to file such a report, that (1) the failure to file the report is his first such failure during the previous 20 consecutive calendar quarters, and (2) the amount of the total contributions due for the calendar quarter of such report (or, in the case of an employer who is required to file the reports on a monthly basis, the amount of the total contributions due for the calendar quarter that includes the month of such report) is less than $500.

Except as otherwise provided in this Section, for any month which begins on or after July 1, 2012, a report of the wages paid to each of an employer's workers shall be due on or before the last day of the month next following the calendar month in which the wages were paid. In the case of an employer who reported wages paid for a total of at least one but fewer than 5 workers for the immediately preceding calendar year, a report of the wages paid to each of the employer's workers shall be due on or before the last day of the month next following the calendar quarter in which the wages were paid.

Any employer who wilfully fails to pay any contribution or part thereof, based upon wages paid prior to 1987, when required by the provisions of this Act and the regulations of the Director, with intent to defraud the Director, shall in addition to such contribution or part thereof pay to the Director a penalty equal to 50 percent of the amount of such contribution or part thereof, as the case may be, provided that the penalty shall not be less than $200.

Any employer who willfully fails to pay any contribution or part thereof, based upon wages paid in 1987 and in each calendar year thereafter, when required by the provisions of this Act and the regulations of the Director, with intent to defraud the Director, shall in addition to such contribution or part thereof pay to the Director a penalty equal to 60% of the amount of such contribution or part thereof, as the case may be, provided that the penalty shall not be less than $400.

However, all or part of any penalty may be waived by the Director for good cause shown.

(Source: P.A. 94-723, eff. 1-19-06.)

(820 ILCS 405/1404) (from Ch. 48, par. 554)

Sec. 1404. Payments in lieu of contributions by nonprofit organizations. A. For the year 1972 and for each calendar year thereafter, contributions shall accrue and become payable, pursuant to Section 1400, by each nonprofit organization (defined in Section 211.2) upon the wages paid by it with

respect to employment after 1971, unless the nonprofit organization elects, in accordance with the provisions of this Section, to pay, in lieu of contributions, an amount equal to the amount of regular benefits and one-half the amount of extended benefits (defined in Section 409) paid to individuals, for any weeks which begin on or after the effective date of the election, on the basis of wages for insured work paid to them by such nonprofit organization during the effective period of such election. Notwithstanding the preceding provisions of this subsection and the provisions of subsection D, with respect to benefit years beginning prior to July 1, 1989, any adjustment after September 30, 1989 to the base period wages paid to the individual by any employer shall not affect the ratio for determining the payments in lieu of contributions of a nonprofit organization which has elected to make payments in lieu of contributions. Provided, however, that with respect to benefit years beginning on or after July 1, 1989, the nonprofit organization shall be required to make payments equal to 100% of regular benefits, including dependents' allowances, and 50% of extended benefits, including dependents' allowances, paid to an individual with respect to benefit years beginning during the effective period of the election, but only if the nonprofit organization: (a) is the last employer as provided in Section 1502.1 and (b) paid to the individual receiving benefits, wages for insured work during his base period. If the nonprofit organization described in this paragraph meets the

requirements of (a) but not (b), with respect to benefit years beginning on or after July 1, 1989, it shall be required to make payments in an amount equal to 50% of regular benefits, including dependents' allowances, and 25% of extended benefits, including dependents' allowances, paid to an individual with respect to benefit years beginning during the effective period of the election.

1. Any employing unit which becomes a nonprofit organization on January 1, 1972, may elect to make payments in lieu of contributions for not less than one calendar year beginning with January 1, 1972, provided that it files its written election with the Director not later than January 31, 1972.

2. Any employing unit which becomes a nonprofit organization after January 1, 1972, may elect to make payments in lieu of contributions for a period of not less than one calendar year beginning as of the first day with respect to which it would, in the absence of its election, incur liability for the payment of contributions, provided that it files its written election with the Director not later than 30 days immediately following the end of the calendar quarter in which it becomes a nonprofit organization.

3. A nonprofit organization which has incurred liability for the payment of contributions for at least 2 calendar years and is not delinquent in such payment and in the payment of any interest or penalties which may have accrued, may elect to make

payments in lieu of contributions beginning January 1 of any calendar year, provided that it files its written election with the Director prior to such January 1, and provided, further, that such election shall be for a period of not less than 2 calendar years.

4. An election to make payments in lieu of contributions shall not terminate any liability incurred by an employer for the payment of contributions, interest or penalties with respect to any calendar quarter <u>(or month, as the case may be)</u> which ends prior to the effective period of the election.

5. A nonprofit organization which has elected, pursuant to paragraph 1, 2, or 3, to make payments in lieu of contributions may terminate the effective period of the election as of January 1 of any calendar year subsequent to the required minimum period of the election only if, prior to such January 1, it files with the Director a written notice to that effect. Upon such termination, the organization shall become liable for the payment of contributions upon wages for insured work paid by it on and after such January 1 and, notwithstanding such termination, it shall continue to be liable for payments in lieu of contributions with respect to benefits paid to individuals on and after such January 1, with respect to benefit years beginning prior to July 1, 1989, on the basis of wages for insured work paid to them by the nonprofit organization prior to such January 1, and, with respect to benefit years beginning after June 30, 1989, if such employer

was the last employer as provided in Section 1502.1 during a benefit year beginning prior to such January 1.

6. Written elections to make payments in lieu of contributions and written notices of termination of election shall be filed in such form and shall contain such information as the Director may prescribe. Upon the filing of such election or notice, the Director shall either order it approved, or, if it appears to the Director that the nonprofit organization has not filed such election or notice within the time prescribed, he shall order it disapproved. The Director shall serve notice of his order upon the nonprofit organization. The Director's order shall be final and conclusive upon the nonprofit organization unless, within 15 days after the date of mailing of notice thereof, the nonprofit organization files with the Director an application for its review, setting forth its reasons in support thereof. Upon receipt of an application for review within the time prescribed, the Director shall order it allowed, or shall order that it be denied, and shall serve notice upon the nonprofit organization of his order. All of the provisions of Section 1509, applicable to orders denying applications for review of determinations of employers' rates of contribution and not inconsistent with the provisions of this subsection, shall be applicable to an order denying an application for review filed pursuant to this subsection.

B. As soon as practicable following the close of each calendar quarter, the Director shall mail to each nonprofit

organization which has elected to make payments in lieu of contributions a Statement of the amount due from it for the regular and one-half the extended benefits paid (or the amounts otherwise provided for in subsection A) during the calendar quarter, together with the names of its workers or former workers and the amounts of benefits paid to each of them during the calendar quarter, with respect to benefit years beginning prior to July 1, 1989, on the basis of wages for insured work paid to them by the nonprofit organization; or, with respect to benefit years beginning after June 30, 1989, if such nonprofit organization was the last employer as provided in Section 1502.1 with respect to a benefit year beginning during the effective period of the election. The amount due shall be payable, and the nonprofit organization shall make payment of such amount not later than 30 days after the date of mailing of the Statement. The Statement shall be final and conclusive upon the nonprofit organization unless, within 20 days after the date of mailing of the Statement, the nonprofit organization files with the Director an application for revision thereof. Such application shall specify wherein the nonprofit organization believes the Statement to be incorrect, and shall set forth its reasons for such belief. All of the provisions of Section 1508, applicable to applications for revision of Statements of Benefit Wages and Statements of Benefit Charges and not inconsistent with the provisions of this subsection, shall be applicable to an application for revision of a

Statement filed pursuant to this subsection.

1. Payments in lieu of contributions made by any nonprofit organization shall not be deducted or deductible, in whole or in part, from the remuneration of individuals in the employ of the organization, nor shall any nonprofit organization require or accept any waiver of any right under this Act by an individual in its employ. The making of any such deduction or the requirement or acceptance of any such waiver is a Class A misdemeanor. Any agreement by an individual in the employ of any person or concern to pay all or any portion of a payment in lieu of contributions, required under this Act from a nonprofit organization, is void.

2. A nonprofit organization which fails to make any payment in lieu of contributions when due under the provisions of this subsection shall pay interest thereon at the rates specified in Section 1401. A nonprofit organization which has elected to make payments in lieu of contributions shall be subject to the penalty provisions of Section 1402. In the making of any payment in lieu of contributions or in the payment of any interest or penalties, a fractional part of a cent shall be disregarded unless it amounts to one-half cent or more, in which case it shall be increased to one cent.

3. All of the remedies available to the Director under the provisions of this Act or of any other law to enforce the payment of contributions, interest, or penalties under this Act, including the making of determinations and assessments

pursuant to Section 2200, are applicable to the enforcement of payments in lieu of contributions and of interest and penalties, due under the provisions of this Section. For the purposes of this paragraph, the term "contribution" or "contributions" which appears in any such provision means "payment in lieu of contributions" or "payments in lieu of contributions." The term "contribution" which appears in Section 2800 also means "payment in lieu of contributions."

4. All of the provisions of Sections 2201 and 2201.1, applicable to adjustment or refund of contributions, interest and penalties erroneously paid and not inconsistent with the provisions of this Section, shall be applicable to payments in lieu of contributions erroneously made or interest or penalties erroneously paid by a nonprofit organization.

5. Payment in lieu of contributions shall be due with respect to any sum erroneously paid as benefits to an individual unless such sum has been recouped pursuant to Section 900 or has otherwise been recovered. If such payment in lieu of contributions has been made, the amount thereof shall be adjusted or refunded in accordance with the provisions of paragraph 4 and Section 2201 if recoupment or other recovery has been made.

6. A nonprofit organization which has elected to make payments in lieu of contributions and thereafter ceases to be an employer shall continue to be liable for payments in lieu of contributions with respect to benefits paid to individuals on

and after the date it has ceased to be an employer, with respect to benefit years beginning prior to July 1, 1989, on the basis of wages for insured work paid to them by it prior to the date it ceased to be an employer, and, with respect to benefit years beginning after June 30, 1989, if such employer was the last employer as provided in Section 1502.1 prior to the date that it ceased to be an employer.

7. With respect to benefit years beginning prior to July 1, 1989, wages paid to an individual during his base period, by a nonprofit organization which elects to make payments in lieu of contributions, for less than full time work, performed during the same weeks in the base period during which the individual had other insured work, shall not be subject to payments in lieu of contributions (upon such employer's request pursuant to the regulation of the Director) so long as the employer continued after the end of the base period, and continues during the applicable benefit year, to furnish such less than full time work to the individual on the same basis and in substantially the same amount as during the base period. If the individual is paid benefits with respect to a week (in the applicable benefit year) after the employer has ceased to furnish the work hereinabove described, the nonprofit organization shall be liable for payments in lieu of contributions with respect to the benefits paid to the individual after the date on which the nonprofit organization ceases to furnish the work.

C. With respect to benefit years beginning prior to July 1, 1989, whenever benefits have been paid to an individual on the basis of wages for insured work paid to him by a nonprofit organization, and the organization incurred liability for the payment of contributions on some of the wages because only a part of the individual's base period was within the effective period of the organization's written election to make payments in lieu of contributions, the organization shall pay an amount in lieu of contributions which bears the same ratio to the total benefits paid to the individual as the total wages for insured work paid to him during the base period by the organization upon which it did not incur liability for the payment of contributions (for the aforesaid reason) bear to the total wages for insured work paid to the individual during the base period by the organization.

D. With respect to benefit years beginning prior to July 1, 1989, whenever benefits have been paid to an individual on the basis of wages for insured work paid to him by a nonprofit organization which has elected to make payments in lieu of contributions, and by one or more other employers, the nonprofit organization shall pay an amount in lieu of contributions which bears the same ratio to the total benefits paid to the individual as the wages for insured work paid to the individual during his base period by the nonprofit organization bear to the total wages for insured work paid to the individual during the base period by all of the employers.

If the nonprofit organization incurred liability for the payment of contributions on some of the wages for insured work paid to the individual, it shall be treated, with respect to such wages, as one of the other employers for the purposes of this paragraph.

E. Two or more nonprofit organizations which have elected to make payments in lieu of contributions may file a joint application with the Director for the establishment of a group account, effective January 1 of any calendar year, for the purpose of sharing the cost of benefits paid on the basis of the wages for insured work paid by such nonprofit organizations, provided that such joint application is filed with the Director prior to such January 1. The application shall identify and authorize a group representative to act as the group's agent for the purposes of this paragraph, and shall be filed in such form and shall contain such information as the Director may prescribe. Upon his approval of a joint application, the Director shall, by order, establish a group account for the applicants and shall serve notice upon the group's representative of such order. Such account shall remain in effect for not less than 2 calendar years and thereafter until terminated by the Director for good cause or, as of the close of any calendar quarter, upon application by the group. Upon establishment of the account, the group shall be liable to the Director for payments in lieu of contributions in an amount equal to the total amount for which, in the absence of the

group account, liability would have been incurred by all of its members; provided, with respect to benefit years beginning prior to July 1, 1989, that the liability of any member to the Director with respect to any payment in lieu of contributions, interest or penalties not paid by the group when due with respect to any calendar quarter shall be in an amount which bears the same ratio to the total benefits paid during such quarter on the basis of the wages for insured work paid by all members of the group as the total wages for insured work paid by such member during such quarter bear to the total wages for insured work paid during the quarter by all members of the group, and, with respect to benefit years beginning on or after July 1, 1989, that the liability of any member to the Director with respect to any payment in lieu of contributions, interest or penalties not paid by the group when due with respect to any calendar quarter shall be in an amount which bears the same ratio to the total benefits paid during such quarter to individuals with respect to whom any member of the group was the last employer as provided in Section 1502.1 as the total wages for insured work paid by such member during such quarter bear to the total wages for insured work paid during the quarter by all members of the group. With respect to calendar months and quarters beginning on or after July 1, 2012, the liability of any member to the Director with respect to any penalties that are assessed for failure to file a timely and sufficient report of wages and which are not paid by the group

when due with respect to the calendar month or quarter, as the case may be, shall be in an amount which bears the same ratio to the total penalties due with respect to such month or quarter as the total wages for insured work paid by such member during such month or quarter bear to the total wages for insured work paid during the month or quarter by all members of the group. All of the provisions of this Section applicable to nonprofit organizations which have elected to make payments in lieu of contributions, and not inconsistent with the provisions of this paragraph, shall apply to a group account and, upon its termination, to each former member thereof. The Director shall by regulation prescribe the conditions for establishment, maintenance and termination of group accounts, and for addition of new members to and withdrawal of active members from such accounts.

F. Whenever service of notice is required by this Section, such notice may be given and be complete by depositing it with the United States Mail, addressed to the nonprofit organization (or, in the case of a group account, to its representative) at its last known address. If such organization is represented by counsel in proceedings before the Director, service of notice may be made upon the nonprofit organization by mailing the notice to such counsel.

(Source: P.A. 86-3.)

(820 ILCS 405/1405) (from Ch. 48, par. 555)

Sec. 1405. Financing Benefits for Employees of Local Governments.

A. 1. For the year 1978 and for each calendar year thereafter, contributions shall accrue and become payable, pursuant to Section 1400, by each governmental entity (other than the State of Illinois and its wholly owned instrumentalities) referred to in clause (B) of Section 211.1, upon the wages paid by such entity with respect to employment after 1977, unless the entity elects to make payments in lieu of contributions pursuant to the provisions of subsection B. Notwithstanding the provisions of Sections 1500 to 1510, inclusive, a governmental entity which has not made such election shall, for liability for contributions incurred prior to January 1, 1984, pay contributions equal to 1 percent with respect to wages for insured work paid during each such calendar year or portion of such year as may be applicable. As used in this subsection, the word "wages", defined in Section 234, is subject to all of the provisions of Section 235.

2. An Indian tribe for which service is exempted from the federal unemployment tax under Section 3306(c)(7) of the Federal Unemployment Tax Act may elect to make payments in lieu of contributions in the same manner and subject to the same conditions as provided in this Section with regard to governmental entities, except as otherwise provided in paragraphs 7, 8, and 9 of subsection B.

B. Any governmental entity subject to subsection A may

elect to make payments in lieu of contributions, in amounts equal to the amounts of regular and extended benefits paid to individuals, for any weeks which begin on or after the effective date of the election, on the basis of wages for insured work paid to them by the entity during the effective period of such election. Notwithstanding the preceding provisions of this subsection and the provisions of subsection D of Section 1404, with respect to benefit years beginning prior to July 1, 1989, any adjustment after September 30, 1989 to the base period wages paid to the individual by any employer shall not affect the ratio for determining payments in lieu of contributions of a governmental entity which has elected to make payments in lieu of contributions. Provided, however, that with respect to benefit years beginning on or after July 1, 1989, the governmental entity shall be required to make payments equal to 100% of regular benefits, including dependents' allowances, and 100% of extended benefits, including dependents' allowances, paid to an individual with respect to benefit years beginning during the effective period of the election, but only if the governmental entity: (a) is the last employer as provided in Section 1502.1 and (b) paid to the individual receiving benefits, wages for insured work during his base period. If the governmental entity described in this paragraph meets the requirements of (a) but not (b), with respect to benefit years beginning on or after July 1, 1989, it shall be required to make payments in an amount equal to 50% of

regular benefits, including dependents' allowances, and 50% of extended benefits, including dependents' allowances, paid to an individual with respect to benefit years beginning during the effective period of the election.

1. Any such governmental entity which becomes an employer on January 1, 1978 pursuant to Section 205 may elect to make payments in lieu of contributions for not less than one calendar year beginning with January 1, 1978, provided that it files its written election with the Director not later than January 31, 1978.

2. A governmental entity newly created after January 1, 1978, may elect to make payments in lieu of contributions for a period of not less than one calendar year beginning as of the first day with respect to which it would, in the absence of its election, incur liability for the payment of contributions, provided that it files its written election with the Director not later than 30 days immediately following the end of the calendar quarter in which it has been created.

3. A governmental entity which has incurred liability for the payment of contributions for at least 2 calendar years, and is not delinquent in such payment and in the payment of any interest or penalties which may have accrued, may elect to make payments in lieu of contributions beginning January 1 of any calendar year, provided that it files its written election with the Director prior to such January 1, and provided, further, that such election shall be for a period of not less than 2

calendar years.

4. An election to make payments in lieu of contributions shall not terminate any liability incurred by a governmental entity for the payment of contributions, interest or penalties with respect to any calendar quarter (or month, as the case may be) which ends prior to the effective period of the election.

5. The termination by a governmental entity of the effective period of its election to make payments in lieu of contributions, and the filing of and subsequent action upon written notices of termination of election, shall be governed by the provisions of paragraphs 5 and 6 of Section 1404A, pertaining to nonprofit organizations.

6. With respect to benefit years beginning prior to July 1, 1989, wages paid to an individual during his base period by a governmental entity which elects to make payments in lieu of contributions for less than full time work, performed during the same weeks in the base period during which the individual had other insured work, shall not be subject to payments in lieu of contribution (upon such employer's request pursuant to the regulation of the Director) so long as the employer continued after the end of the base period, and continues during the applicable benefit year, to furnish such less than full time work to the individual on the same basis and in substantially the same amount as during the base period. If the individual is paid benefits with respect to a week (in the applicable benefit year) after the employer has ceased to

furnish the work hereinabove described, the governmental entity shall be liable for payments in lieu of contributions with respect to the benefits paid to the individual after the date on which the governmental entity ceases to furnish the work.

7. An Indian tribe may elect to make payments in lieu of contributions for calendar year 2003, provided that it files its written election with the Director not later than January 31, 2003, and provided further that it is not delinquent in the payment of any contributions, interest, or penalties.

8. Failure of an Indian tribe to make a payment in lieu of contributions, or a payment of interest or penalties due under this Act, within 90 days after the Department serves notice of the finality of a determination and assessment shall cause the Indian tribe to lose the option of making payments in lieu of contributions, effective as of the calendar year immediately following the date on which the Department serves the notice. Notice of the loss of the option to make payments in lieu of contributions may be protested in the same manner as a determination and assessment under Section 2200 of this Act.

9. An Indian tribe that, pursuant to paragraph 8, loses the option of making payments in lieu of contributions may again elect to make payments in lieu of contributions for a calendar year if: (a) the Indian tribe has incurred liability for the payment of contributions for at least one calendar year since losing the option pursuant to paragraph 8, (b) the Indian tribe

is not delinquent in the payment of any liabilities under the Act, including interest or penalties, and (c) the Indian tribe files its written election with the Director not later than January 31 of the year with respect to which it is making the election.

C. As soon as practicable following the close of each calendar quarter, the Director shall mail to each governmental entity which has elected to make payments in lieu of contributions a Statement of the amount due from it for all the regular and extended benefits paid during the calendar quarter, together with the names of its workers or former workers and the amounts of benefits paid to each of them during the calendar quarter with respect to benefit years beginning prior to July 1, 1989, on the basis of wages for insured work paid to them by the governmental entity; or, with respect to benefit years beginning after June 30, 1989, if such governmental entity was the last employer as provided in Section 1502.1 with respect to a benefit year beginning during the effective period of the election. All of the provisions of subsection B of Section 1404 pertaining to nonprofit organizations, not inconsistent with the preceding sentence, shall be applicable to payments in lieu of contributions by a governmental entity.

D. The provisions of subsections C through F, inclusive, of Section 1404, pertaining to nonprofit organizations, shall be applicable to each governmental entity which has elected to make payments in lieu of contributions.

E. 1. If an Indian tribe fails to pay any liability under this Act (including assessments of interest or penalty) within 90 days after the Department issues a notice of the finality of a determination and assessment, the Director shall immediately notify the United States Internal Revenue Service and the United States Department of Labor.

2. Notices of payment and reporting delinquencies to Indian tribes shall include information that failure to make full payment within the prescribed time frame:

a. will cause the Indian tribe to lose the exemption provided by Section 3306(c)(7) of the Federal Unemployment Tax Act with respect to the federal unemployment tax;

b. will cause the Indian tribe to lose the option to make payments in lieu of contributions.

(Source: P.A. 92-555, eff. 6-24-02.)

(820 ILCS 405/1801.1)

Sec. 1801.1. Directory of New Hires.

A. The Director shall establish and operate an automated directory of newly hired employees which shall be known as the "Illinois Directory of New Hires" which shall contain the information required to be reported by employers to the Department under subsection B. In the administration of the Directory, the Director shall comply with any requirements concerning the Employer New Hire Reporting Program established by the federal Personal Responsibility and Work Opportunity

Reconciliation Act of 1996. The Director is authorized to use the information contained in the Directory of New Hires to administer any of the provisions of this Act.

B. Each employer in Illinois, except a department, agency, or instrumentality of the United States, shall file with the Department a report in accordance with rules adopted by the Department (but in any event not later than 20 days after the date the employer hires the employee or, in the case of an employer transmitting reports magnetically or electronically, by 2 monthly transmissions, if necessary, not less than 12 days nor more than 16 days apart) providing the following information concerning each newly hired employee: the employee's name, address, and social security number, the date services for remuneration were first performed by the employee, the employee's projected monthly wages, and the employer's name, address, Federal Employer Identification Number assigned under Section 6109 of the Internal Revenue Code of 1986, and such other information as may be required by federal law or regulation, provided that each employer may voluntarily file the address to which the employer wants income withholding orders to be mailed, if it is different from the address given on the Federal Employer Identification Number. An employer in Illinois which transmits its reports electronically or magnetically and which also has employees in another state may report all newly hired employees to a single designated state in which the employer has employees if it has so notified the

Secretary of the United States Department of Health and Human Services in writing. An employer may, at its option, submit information regarding any rehired employee in the same manner as information is submitted regarding a newly hired employee. Each report required under this subsection shall, to the extent practicable, be made on an Internal Revenue Service Form W-4 or, at the option of the employer, an equivalent form, and may be transmitted by first class mail, by telefax, magnetically, or electronically.

C. An employer which knowingly fails to comply with the reporting requirements established by this Section shall be subject to a civil penalty of $15 for each individual whom it fails to report. An employer shall be considered to have knowingly failed to comply with the reporting requirements established by this Section with respect to an individual if the employer has been notified by the Department that it has failed to report an individual, and it fails, without reasonable cause, to supply the required information to the Department within 21 days after the date of mailing of the notice. Any individual who knowingly conspires with the newly hired employee to cause the employer to fail to report the information required by this Section or who knowingly conspires with the newly hired employee to cause the employer to file a false or incomplete report shall be guilty of a Class B misdemeanor with a fine not to exceed $500 with respect to each employee with whom the individual so conspires.

D. As used in this Section, "newly hired employee" means an individual who is an employee within the meaning of Chapter 24 of the Internal Revenue Code of 1986, and whose reporting to work which results in earnings from the employer is the first instance within the preceding 180 days that the individual has reported for work for which earnings were received from that employer; however, "newly hired employee" does not include an employee of a federal or State agency performing intelligence or counterintelligence functions, if the head of that agency has determined that the filing of the report required by this Section with respect to the employee could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

Notwithstanding Section 205, and for the purposes of this Section only, the term "employer" has the meaning given by Section 3401(d) of the Internal Revenue Code of 1986 and includes any governmental entity and labor organization as defined by Section 2(5) of the National Labor Relations Act, and includes any entity (also known as a hiring hall) which is used by the organization and an employer to carry out the requirements described in Section 8(f)(3) of that Act of an agreement between the organization and the employer.

(Source: P.A. 97-621, eff. 11-18-11.)

(820 ILCS 405/1900) (from Ch. 48, par. 640)

Sec. 1900. Disclosure of information.

A. Except as provided in this Section, information obtained from any individual or employing unit during the administration of this Act shall:

1. be confidential,

2. not be published or open to public inspection,

3. not be used in any court in any pending action or proceeding,

4. not be admissible in evidence in any action or proceeding other than one arising out of this Act.

B. No finding, determination, decision, ruling or order (including any finding of fact, statement or conclusion made therein) issued pursuant to this Act shall be admissible or used in evidence in any action other than one arising out of this Act, nor shall it be binding or conclusive except as provided in this Act, nor shall it constitute res judicata, regardless of whether the actions were between the same or related parties or involved the same facts.

C. Any officer or employee of this State, any officer or employee of any entity authorized to obtain information pursuant to this Section, and any agent of this State or of such entity who, except with authority of the Director under this Section, shall disclose information shall be guilty of a Class B misdemeanor and shall be disqualified from holding any appointment or employment by the State.

D. An individual or his duly authorized agent may be supplied with information from records only to the extent

necessary for the proper presentation of his claim for benefits or with his existing or prospective rights to benefits. Discretion to disclose this information belongs solely to the Director and is not subject to a release or waiver by the individual. Notwithstanding any other provision to the contrary, an individual or his or her duly authorized agent may be supplied with a statement of the amount of benefits paid to the individual during the 18 months preceding the date of his or her request.

E. An employing unit may be furnished with information, only if deemed by the Director as necessary to enable it to fully discharge its obligations or safeguard its rights under the Act. Discretion to disclose this information belongs solely to the Director and is not subject to a release or waiver by the employing unit.

F. The Director may furnish any information that he may deem proper to any public officer or public agency of this or any other State or of the federal government dealing with:

1. the administration of relief,

2. public assistance,

3. unemployment compensation,

4. a system of public employment offices,

5. wages and hours of employment, or

6. a public works program.

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.

G. The Director may disclose information submitted by the State or any of its political subdivisions, municipal corporations, instrumentalities, or school or community college districts, except for information which specifically identifies an individual claimant.

H. The Director shall disclose only that information required to be disclosed under Section 303 of the Social Security Act, as amended, including:

1. any information required to be given the United States Department of Labor under Section 303(a)(6); and

2. the making available upon request to any agency of the United States charged with the administration of public works or assistance through public employment, the name, address, ordinary occupation and employment status of each recipient of unemployment compensation, and a statement of such recipient's right to further compensation under such law as required by Section 303(a)(7); and

3. records to make available to the Railroad Retirement Board as required by Section 303(c)(1); and

4. information that will assure reasonable cooperation with every agency of the United States charged with the administration of any unemployment compensation law as required by Section 303(c)(2); and

5. information upon request and on a reimbursable basis to the United States Department of Agriculture and to any State food stamp agency concerning any information required to be furnished by Section 303(d); and

6. any wage information upon request and on a reimbursable basis to any State or local child support enforcement agency required by Section 303(e); and

7. any information required under the income eligibility and verification system as required by Section 303(f); and

8. information that might be useful in locating an absent parent or that parent's employer, establishing paternity or establishing, modifying, or enforcing child support orders for the purpose of a child support enforcement program under Title IV of the Social Security Act upon the request of and on a reimbursable basis to the public agency administering the Federal Parent Locator Service as required by Section 303(h); and

9. information, upon request, to representatives of any federal, State or local governmental public housing agency with respect to individuals who have signed the appropriate consent form approved by the Secretary of Housing and Urban Development and who are applying for or participating in any housing assistance program administered by the United States Department of Housing and Urban Development as required by Section 303(i).

I. The Director, upon the request of a public agency of Illinois, of the federal government or of any other state charged with the investigation or enforcement of Section 10-5 of the Criminal Code of 1961 (or a similar federal law or similar law of another State), may furnish the public agency information regarding the individual specified in the request as to:

1. the current or most recent home address of the individual, and

2. the names and addresses of the individual's employers.

J. Nothing in this Section shall be deemed to interfere with the disclosure of certain records as provided for in Section 1706 or with the right to make available to the Internal Revenue Service of the United States Department of the Treasury, or the Department of Revenue of the State of Illinois, information obtained under this Act.

K. The Department shall make available to the Illinois Student Assistance Commission, upon request, information in the possession of the Department that may be necessary or useful to the Commission in the collection of defaulted or delinquent student loans which the Commission administers.

L. The Department shall make available to the State Employees' Retirement System, the State Universities Retirement System, the Teachers' Retirement System of the State of Illinois, and the Department of Central Management Services,

Risk Management Division, upon request, information in the possession of the Department that may be necessary or useful to the System or the Risk Management Division for the purpose of determining whether any recipient of a disability benefit from the System or a workers' compensation benefit from the Risk Management Division is gainfully employed.

M. This Section shall be applicable to the information obtained in the administration of the State employment service, except that the Director may publish or release general labor market information and may furnish information that he may deem proper to an individual, public officer or public agency of this or any other State or the federal government (in addition to those public officers or public agencies specified in this Section) as he prescribes by Rule.

N. The Director may require such safeguards as he deems proper to insure that information disclosed pursuant to this Section is used only for the purposes set forth in this Section.

O. Nothing in this Section prohibits communication with an individual or entity through unencrypted e-mail or other unencrypted electronic means as long as the communication does not contain the individual's or entity's name in combination with any one or more of the individual's or entity's social security number; driver's license or State identification number; account number or credit or debit card number; or any required security code, access code, or password that would

permit access to further information pertaining to the individual or entity.

P. Within 30 days after the effective date of this amendatory Act of 1993 and annually thereafter, the Department shall provide to the Department of Financial Institutions a list of individuals or entities that, for the most recently completed calendar year, report to the Department as paying wages to workers. The lists shall be deemed confidential and may not be disclosed to any other person.

Q. The Director shall make available to an elected federal official the name and address of an individual or entity that is located within the jurisdiction from which the official was elected and that, for the most recently completed calendar year, has reported to the Department as paying wages to workers, where the information will be used in connection with the official duties of the official and the official requests the information in writing, specifying the purposes for which it will be used. For purposes of this subsection, the use of information in connection with the official duties of an official does not include use of the information in connection with the solicitation of contributions or expenditures, in money or in kind, to or on behalf of a candidate for public or political office or a political party or with respect to a public question, as defined in Section 1-3 of the Election Code, or in connection with any commercial solicitation. Any elected federal official who, in submitting a request for

information covered by this subsection, knowingly makes a false statement or fails to disclose a material fact, with the intent to obtain the information for a purpose not authorized by this subsection, shall be guilty of a Class B misdemeanor.

R. The Director may provide to any State or local child support agency, upon request and on a reimbursable basis, information that might be useful in locating an absent parent or that parent's employer, establishing paternity, or establishing, modifying, or enforcing child support orders.

S. The Department shall make available to a State's Attorney of this State or a State's Attorney's investigator, upon request, the current address or, if the current address is unavailable, current employer information, if available, of a victim of a felony or a witness to a felony or a person against whom an arrest warrant is outstanding.

T. The Director shall make available to the Department of State Police, a county sheriff's office, or a municipal police department, upon request, any information concerning the current address and place of employment or former places of employment of a person who is required to register as a sex offender under the Sex Offender Registration Act that may be useful in enforcing the registration provisions of that Act.

U. The Director shall make information available to the Department of Healthcare and Family Services and the Department of Human Services for the purpose of determining eligibility for public benefit programs authorized under the Illinois

Public Aid Code and related statutes administered by those departments, for verifying sources and amounts of income, and for other purposes directly connected with the administration of those programs.

(Source: P.A. 96-420, eff. 8-13-09; 97-621, eff. 11-18-11.)

Section 905. The State Comptroller Act is amended by changing Section 10.05 as follows:

(15 ILCS 405/10.05) (from Ch. 15, par. 210.05)

Sec. 10.05. Deductions from warrants; statement of reason for deduction. Whenever any person shall be entitled to a warrant or other payment from the treasury or other funds held by the State Treasurer, on any account, against whom there shall be any then due and payable account or claim in favor of the State, the United States upon certification by the Secretary of the Treasury of the United States, or his or her delegate, pursuant to a reciprocal offset agreement under subsection (i-1) of Section 10 of the Illinois State Collection Act of 1986, or a unit of local government, a school district, or a public institution of higher education, as defined in Section 1 of the Board of Higher Education Act, upon certification by that entity, the Comptroller, upon notification thereof, shall ascertain the amount due and payable to the State, the United States, the unit of local government, the school district, or the public institution of

higher education, as aforesaid, and draw a warrant on the treasury or on other funds held by the State Treasurer, stating the amount for which the party was entitled to a warrant or other payment, the amount deducted therefrom, and on what account, and directing the payment of the balance; which warrant or payment as so drawn shall be entered on the books of the Treasurer, and such balance only shall be paid. The Comptroller may deduct any one or more of the following: (i) the entire amount due and payable to the State or a portion of the amount due and payable to the State in accordance with the request of the notifying agency; (ii) the entire amount due and payable to the United States or a portion of the amount due and payable to the United States in accordance with a reciprocal offset agreement under subsection (i-1) of Section 10 of the Illinois State Collection Act of 1986; or (iii) the entire amount due and payable to the unit of local government, school district, or public institution of higher education or a portion of the amount due and payable to that entity in accordance with an intergovernmental agreement authorized under this Section and Section 10.05d. No request from a notifying agency, the Secretary of the Treasury of the United States, a unit of local government, a school district, or a public institution of higher education for an amount to be deducted under this Section from a wage or salary payment, or from a contractual payment to an individual for personal services, shall exceed 25% of the net amount of such payment.

"Net amount" means that part of the earnings of an individual remaining after deduction of any amounts required by law to be withheld. For purposes of this provision, wage, salary or other payments for personal services shall not include final compensation payments for the value of accrued vacation, overtime or sick leave. Whenever the Comptroller draws a warrant or makes a payment involving a deduction ordered under this Section, the Comptroller shall notify the payee and the State agency that submitted the voucher of the reason for the deduction and he or she shall retain a record of such statement in his or her records. As used in this Section, an "account or claim in favor of the State" includes all amounts owing to "State agencies" as defined in Section 7 of this Act. However, the Comptroller shall not be required to accept accounts or claims owing to funds not held by the State Treasurer, where such accounts or claims do not exceed $50, nor shall the Comptroller deduct from funds held by the State Treasurer under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or for payments to institutions from the Illinois Prepaid Tuition Trust Fund (unless the Trust Fund moneys are used for child support). The Comptroller and the Department of Revenue shall enter into an interagency agreement to establish responsibilities, duties, and procedures relating to deductions from lottery prizes awarded under Section 20.1 of the Illinois Lottery Law. The Comptroller may enter into an intergovernmental agreement with

the Department of Revenue and the Secretary of the Treasury of the United States, or his or her delegate, to establish responsibilities, duties, and procedures relating to reciprocal offset of delinquent State and federal obligations pursuant to subsection (i-1) of Section 10 of the Illinois State Collection Act of 1986. The Comptroller may enter into intergovernmental agreements with any unit of local government, school district, or public institution of higher education to establish responsibilities, duties, and procedures to provide for the offset, by the Comptroller, of obligations owed to those entities.

(Source: P.A. 97-269, eff. 12-16-11 (see Section 15 of P.A. 97-632 for the effective date of changes made by P.A. 97-269); 97-632, eff. 12-16-11.)

Section 910. The State Finance Act is amended by changing Section 6z-81 as follows:

(30 ILCS 105/6z-81)

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

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

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

(1) Subject to appropriation, for payment by the

Department of Healthcare and Family Services or by the Department of Human Services of medical bills and related expenses, including administrative expenses, for which the State is responsible under Titles XIX and XXI of the Social Security Act, the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, and the Long Term Acute Care Hospital Quality Improvement Transfer Program Act. ~~, and the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.~~

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

(c) The Fund shall consist of the following:

(1) Moneys received by the State from short-term borrowing pursuant to the Short Term Borrowing Act on or after the effective date of this amendatory Act of the 96th General Assembly.

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

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

(4) All other moneys received for the Fund from any

other source, including interest earned thereon.

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

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

(Source: P.A. 96-820, eff. 11-18-09; 96-1100, eff. 1-1-11; 97-44, eff. 6-28-11; 97-641, eff. 12-19-11.)

Section 915. The Downstate Public Transportation Act is amended by changing Sections 2-15.2 and 2-15.3 as follows:

(30 ILCS 740/2-15.2)

Sec. 2-15.2. Free services; eligibility.

(a) Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly and until subsection (b) is implemented, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, every participant, as defined in Section 2-2.02 (1)(a),

shall be provided without charge to all senior citizen residents of the participant aged 65 and older, under such conditions as shall be prescribed by the participant.

(b) Notwithstanding any law to the contrary, no later than 180 days following the effective date of this amendatory Act of the 96th General Assembly, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, every participant, as defined in Section 2-2.02 (1)(a), shall be provided without charge to senior citizens aged 65 and older who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such conditions as shall be prescribed by the participant. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section. Nothing in this Section shall relieve the participant from providing reduced fares as may be required by federal law.

(Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

(30 ILCS 740/2-15.3)

Sec. 2-15.3. Transit services for disabled individuals. Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th

General Assembly, all fixed route public transportation services provided by, or under grant or purchase of service contract of, any participant shall be provided without charge to all disabled persons who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such procedures as shall be prescribed by the participant. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section.
(Source: P.A. 95-906, eff. 8-26-08.)

Section 920. The Property Tax Code is amended by changing Sections 15-172, 15-175, 20-15, and 21-27 as follows:

(35 ILCS 200/15-172)

Sec. 15-172. Senior Citizens Assessment Freeze Homestead Exemption.

(a) This Section may be cited as the Senior Citizens Assessment Freeze Homestead Exemption.

(b) As used in this Section:

"Applicant" means an individual who has filed an application under this Section.

"Base amount" means the base year equalized assessed value of the residence plus the first year's equalized assessed value

of any added improvements which increased the assessed value of the residence after the base year.

"Base year" means the taxable year prior to the taxable year for which the applicant first qualifies and applies for the exemption provided that in the prior taxable year the property was improved with a permanent structure that was occupied as a residence by the applicant who was liable for paying real property taxes on the property and who was either (i) an owner of record of the property or had legal or equitable interest in the property as evidenced by a written instrument or (ii) had a legal or equitable interest as a lessee in the parcel of property that was single family residence. If in any subsequent taxable year for which the applicant applies and qualifies for the exemption the equalized assessed value of the residence is less than the equalized assessed value in the existing base year (provided that such equalized assessed value is not based on an assessed value that results from a temporary irregularity in the property that reduces the assessed value for one or more taxable years), then that subsequent taxable year shall become the base year until a new base year is established under the terms of this paragraph. For taxable year 1999 only, the Chief County Assessment Officer shall review (i) all taxable years for which the applicant applied and qualified for the exemption and (ii) the existing base year. The assessment officer shall select as the new base year the year with the lowest equalized assessed value. An

equalized assessed value that is based on an assessed value that results from a temporary irregularity in the property that reduces the assessed value for one or more taxable years shall not be considered the lowest equalized assessed value. The selected year shall be the base year for taxable year 1999 and thereafter until a new base year is established under the terms of this paragraph.

"Chief County Assessment Officer" means the County Assessor or Supervisor of Assessments of the county in which the property is located.

"Equalized assessed value" means the assessed value as equalized by the Illinois Department of Revenue.

"Household" means the applicant, the spouse of the applicant, and all persons using the residence of the applicant as their principal place of residence.

"Household income" means the combined income of the members of a household for the calendar year preceding the taxable year.

"Income" has the same meaning as provided in Section 3.07 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, except that, beginning in assessment year 2001, "income" does not include veteran's benefits.

"Internal Revenue Code of 1986" means the United States Internal Revenue Code of 1986 or any successor law or laws relating to federal income taxes in effect for the year

preceding the taxable year.

"Life care facility that qualifies as a cooperative" means a facility as defined in Section 2 of the Life Care Facilities Act.

"Maximum income limitation" means:

(1) $35,000 prior to taxable year 1999;

(2) $40,000 in taxable years 1999 through 2003;

(3) $45,000 in taxable years 2004 through 2005;

(4) $50,000 in taxable years 2006 and 2007; and

(5) $55,000 in taxable year 2008 and thereafter.

"Residence" means the principal dwelling place and appurtenant structures used for residential purposes in this State occupied on January 1 of the taxable year by a household and so much of the surrounding land, constituting the parcel upon which the dwelling place is situated, as is used for residential purposes. If the Chief County Assessment Officer has established a specific legal description for a portion of property constituting the residence, then that portion of property shall be deemed the residence for the purposes of this Section.

"Taxable year" means the calendar year during which ad valorem property taxes payable in the next succeeding year are levied.

(c) Beginning in taxable year 1994, a senior citizens assessment freeze homestead exemption is granted for real property that is improved with a permanent structure that is

occupied as a residence by an applicant who (i) is 65 years of age or older during the taxable year, (ii) has a household income that does not exceed the maximum income limitation, (iii) is liable for paying real property taxes on the property, and (iv) is an owner of record of the property or has a legal or equitable interest in the property as evidenced by a written instrument. This homestead exemption shall also apply to a leasehold interest in a parcel of property improved with a permanent structure that is a single family residence that is occupied as a residence by a person who (i) is 65 years of age or older during the taxable year, (ii) has a household income that does not exceed the maximum income limitation, (iii) has a legal or equitable ownership interest in the property as lessee, and (iv) is liable for the payment of real property taxes on that property.

In counties of 3,000,000 or more inhabitants, the amount of the exemption for all taxable years is the equalized assessed value of the residence in the taxable year for which application is made minus the base amount. In all other counties, the amount of the exemption is as follows: (i) through taxable year 2005 and for taxable year 2007 and thereafter, the amount of this exemption shall be the equalized assessed value of the residence in the taxable year for which application is made minus the base amount; and (ii) for taxable year 2006, the amount of the exemption is as follows:

(1) For an applicant who has a household income of

$45,000 or less, the amount of the exemption is the equalized assessed value of the residence in the taxable year for which application is made minus the base amount.

(2) For an applicant who has a household income exceeding $45,000 but not exceeding $46,250, the amount of the exemption is (i) the equalized assessed value of the residence in the taxable year for which application is made minus the base amount (ii) multiplied by 0.8.

(3) For an applicant who has a household income exceeding $46,250 but not exceeding $47,500, the amount of the exemption is (i) the equalized assessed value of the residence in the taxable year for which application is made minus the base amount (ii) multiplied by 0.6.

(4) For an applicant who has a household income exceeding $47,500 but not exceeding $48,750, the amount of the exemption is (i) the equalized assessed value of the residence in the taxable year for which application is made minus the base amount (ii) multiplied by 0.4.

(5) For an applicant who has a household income exceeding $48,750 but not exceeding $50,000, the amount of the exemption is (i) the equalized assessed value of the residence in the taxable year for which application is made minus the base amount (ii) multiplied by 0.2.

When the applicant is a surviving spouse of an applicant for a prior year for the same residence for which an exemption under this Section has been granted, the base year and base

amount for that residence are the same as for the applicant for the prior year.

Each year at the time the assessment books are certified to the County Clerk, the Board of Review or Board of Appeals shall give to the County Clerk a list of the assessed values of improvements on each parcel qualifying for this exemption that were added after the base year for this parcel and that increased the assessed value of the property.

In the case of land improved with an apartment building owned and operated as a cooperative or a building that is a life care facility that qualifies as a cooperative, the maximum reduction from the equalized assessed value of the property is limited to the sum of the reductions calculated for each unit occupied as a residence by a person or persons (i) 65 years of age or older, (ii) with a household income that does not exceed the maximum income limitation, (iii) who is liable, by contract with the owner or owners of record, for paying real property taxes on the property, and (iv) who is an owner of record of a legal or equitable interest in the cooperative apartment building, other than a leasehold interest. In the instance of a cooperative where a homestead exemption has been granted under this Section, the cooperative association or its management firm shall credit the savings resulting from that exemption only to the apportioned tax liability of the owner who qualified for the exemption. Any person who willfully refuses to credit that savings to an owner who qualifies for the

exemption is guilty of a Class B misdemeanor.

When a homestead exemption has been granted under this Section and an applicant then becomes a resident of a facility licensed under the Assisted Living and Shared Housing Act, the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act, or the ID/DD Community Care Act, the exemption shall be granted in subsequent years so long as the residence (i) continues to be occupied by the qualified applicant's spouse or (ii) if remaining unoccupied, is still owned by the qualified applicant for the homestead exemption.

Beginning January 1, 1997, when an individual dies who would have qualified for an exemption under this Section, and the surviving spouse does not independently qualify for this exemption because of age, the exemption under this Section shall be granted to the surviving spouse for the taxable year preceding and the taxable year of the death, provided that, except for age, the surviving spouse meets all other qualifications for the granting of this exemption for those years.

When married persons maintain separate residences, the exemption provided for in this Section may be claimed by only one of such persons and for only one residence.

For taxable year 1994 only, in counties having less than 3,000,000 inhabitants, to receive the exemption, a person shall submit an application by February 15, 1995 to the Chief County Assessment Officer of the county in which the property is

located. In counties having 3,000,000 or more inhabitants, for taxable year 1994 and all subsequent taxable years, to receive the exemption, a person may submit an application to the Chief County Assessment Officer of the county in which the property is located during such period as may be specified by the Chief County Assessment Officer. The Chief County Assessment Officer in counties of 3,000,000 or more inhabitants shall annually give notice of the application period by mail or by publication. In counties having less than 3,000,000 inhabitants, beginning with taxable year 1995 and thereafter, to receive the exemption, a person shall submit an application by July 1 of each taxable year to the Chief County Assessment Officer of the county in which the property is located. A county may, by ordinance, establish a date for submission of applications that is different than July 1. The applicant shall submit with the application an affidavit of the applicant's total household income, age, marital status (and if married the name and address of the applicant's spouse, if known), and principal dwelling place of members of the household on January 1 of the taxable year. The Department shall establish, by rule, a method for verifying the accuracy of affidavits filed by applicants under this Section, and the Chief County Assessment Officer may conduct audits of any taxpayer claiming an exemption under this Section to verify that the taxpayer is eligible to receive the exemption. Each application shall contain or be verified by a written declaration that it is made

under the penalties of perjury. A taxpayer's signing a fraudulent application under this Act is perjury, as defined in Section 32-2 of the Criminal Code of 1961. The applications shall be clearly marked as applications for the Senior Citizens Assessment Freeze Homestead Exemption and must contain a notice that any taxpayer who receives the exemption is subject to an audit by the Chief County Assessment Officer.

Notwithstanding any other provision to the contrary, in counties having fewer than 3,000,000 inhabitants, if an applicant fails to file the application required by this Section in a timely manner and this failure to file is due to a mental or physical condition sufficiently severe so as to render the applicant incapable of filing the application in a timely manner, the Chief County Assessment Officer may extend the filing deadline for a period of 30 days after the applicant regains the capability to file the application, but in no case may the filing deadline be extended beyond 3 months of the original filing deadline. In order to receive the extension provided in this paragraph, the applicant shall provide the Chief County Assessment Officer with a signed statement from the applicant's physician stating the nature and extent of the condition, that, in the physician's opinion, the condition was so severe that it rendered the applicant incapable of filing the application in a timely manner, and the date on which the applicant regained the capability to file the application.

Beginning January 1, 1998, notwithstanding any other

provision to the contrary, in counties having fewer than 3,000,000 inhabitants, if an applicant fails to file the application required by this Section in a timely manner and this failure to file is due to a mental or physical condition sufficiently severe so as to render the applicant incapable of filing the application in a timely manner, the Chief County Assessment Officer may extend the filing deadline for a period of 3 months. In order to receive the extension provided in this paragraph, the applicant shall provide the Chief County Assessment Officer with a signed statement from the applicant's physician stating the nature and extent of the condition, and that, in the physician's opinion, the condition was so severe that it rendered the applicant incapable of filing the application in a timely manner.

In counties having less than 3,000,000 inhabitants, if an applicant was denied an exemption in taxable year 1994 and the denial occurred due to an error on the part of an assessment official, or his or her agent or employee, then beginning in taxable year 1997 the applicant's base year, for purposes of determining the amount of the exemption, shall be 1993 rather than 1994. In addition, in taxable year 1997, the applicant's exemption shall also include an amount equal to (i) the amount of any exemption denied to the applicant in taxable year 1995 as a result of using 1994, rather than 1993, as the base year, (ii) the amount of any exemption denied to the applicant in taxable year 1996 as a result of using 1994, rather than 1993,

as the base year, and (iii) the amount of the exemption erroneously denied for taxable year 1994.

For purposes of this Section, a person who will be 65 years of age during the current taxable year shall be eligible to apply for the homestead exemption during that taxable year. Application shall be made during the application period in effect for the county of his or her residence.

The Chief County Assessment Officer may determine the eligibility of a life care facility that qualifies as a cooperative to receive the benefits provided by this Section by use of an affidavit, application, visual inspection, questionnaire, or other reasonable method in order to insure that the tax savings resulting from the exemption are credited by the management firm to the apportioned tax liability of each qualifying resident. The Chief County Assessment Officer may request reasonable proof that the management firm has so credited that exemption.

Except as provided in this Section, all information received by the chief county assessment officer or the Department from applications filed under this Section, or from any investigation conducted under the provisions of this Section, shall be confidential, except for official purposes or pursuant to official procedures for collection of any State or local tax or enforcement of any civil or criminal penalty or sanction imposed by this Act or by any statute or ordinance imposing a State or local tax. Any person who divulges any such

information in any manner, except in accordance with a proper judicial order, is guilty of a Class A misdemeanor.

Nothing contained in this Section shall prevent the Director or chief county assessment officer from publishing or making available reasonable statistics concerning the operation of the exemption contained in this Section in which the contents of claims are grouped into aggregates in such a way that information contained in any individual claim shall not be disclosed.

(d) Each Chief County Assessment Officer shall annually publish a notice of availability of the exemption provided under this Section. The notice shall be published at least 60 days but no more than 75 days prior to the date on which the application must be submitted to the Chief County Assessment Officer of the county in which the property is located. The notice shall appear in a newspaper of general circulation in the county.

Notwithstanding Sections 6 and 8 of the State Mandates Act, no reimbursement by the State is required for the implementation of any mandate created by this Section.

(Source: P.A. 96-339, eff. 7-1-10; 96-355, eff. 1-1-10; 96-1000, eff. 7-2-10; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12; revised 9-12-11.)

(35 ILCS 200/15-175)

Sec. 15-175. General homestead exemption. Except as

provided in Sections 15-176 and 15-177, homestead property is entitled to an annual homestead exemption limited, except as described here with relation to cooperatives, to a reduction in the equalized assessed value of homestead property equal to the increase in equalized assessed value for the current assessment year above the equalized assessed value of the property for 1977, up to the maximum reduction set forth below. If however, the 1977 equalized assessed value upon which taxes were paid is subsequently determined by local assessing officials, the Property Tax Appeal Board, or a court to have been excessive, the equalized assessed value which should have been placed on the property for 1977 shall be used to determine the amount of the exemption.

Except as provided in Section 15-176, the maximum reduction before taxable year 2004 shall be $4,500 in counties with 3,000,000 or more inhabitants and $3,500 in all other counties. Except as provided in Sections 15-176 and 15-177, for taxable years 2004 through 2007, the maximum reduction shall be $5,000, for taxable year 2008, the maximum reduction is $5,500, and, for taxable years 2009 and thereafter, the maximum reduction is $6,000 in all counties. If a county has elected to subject itself to the provisions of Section 15-176 as provided in subsection (k) of that Section, then, for the first taxable year only after the provisions of Section 15-176 no longer apply, for owners who, for the taxable year, have not been granted a senior citizens assessment freeze homestead

exemption under Section 15-172 or a long-time occupant homestead exemption under Section 15-177, there shall be an additional exemption of $5,000 for owners with a household income of $30,000 or less.

In counties with fewer than 3,000,000 inhabitants, if, based on the most recent assessment, the equalized assessed value of the homestead property for the current assessment year is greater than the equalized assessed value of the property for 1977, the owner of the property shall automatically receive the exemption granted under this Section in an amount equal to the increase over the 1977 assessment up to the maximum reduction set forth in this Section.

If in any assessment year beginning with the 2000 assessment year, homestead property has a pro-rata valuation under Section 9-180 resulting in an increase in the assessed valuation, a reduction in equalized assessed valuation equal to the increase in equalized assessed value of the property for the year of the pro-rata valuation above the equalized assessed value of the property for 1977 shall be applied to the property on a proportionate basis for the period the property qualified as homestead property during the assessment year. The maximum proportionate homestead exemption shall not exceed the maximum homestead exemption allowed in the county under this Section divided by 365 and multiplied by the number of days the property qualified as homestead property.

"Homestead property" under this Section includes

residential property that is occupied by its owner or owners as his or their principal dwelling place, or that is a leasehold interest on which a single family residence is situated, which is occupied as a residence by a person who has an ownership interest therein, legal or equitable or as a lessee, and on which the person is liable for the payment of property taxes. For land improved with an apartment building owned and operated as a cooperative or a building which is a life care facility as defined in Section 15-170 and considered to be a cooperative under Section 15-170, the maximum reduction from the equalized assessed value shall be limited to the increase in the value above the equalized assessed value of the property for 1977, up to the maximum reduction set forth above, multiplied by the number of apartments or units occupied by a person or persons who is liable, by contract with the owner or owners of record, for paying property taxes on the property and is an owner of record of a legal or equitable interest in the cooperative apartment building, other than a leasehold interest. For purposes of this Section, the term "life care facility" has the meaning stated in Section 15-170.

"Household", as used in this Section, means the owner, the spouse of the owner, and all persons using the residence of the owner as their principal place of residence.

"Household income", as used in this Section, means the combined income of the members of a household for the calendar year preceding the taxable year.

"Income", as used in this Section, has the same meaning as provided in Section 3.07 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, except that "income" does not include veteran's benefits.

In a cooperative where a homestead exemption has been granted, the cooperative association or its management firm shall credit the savings resulting from that exemption only to the apportioned tax liability of the owner who qualified for the exemption. Any person who willfully refuses to so credit the savings shall be guilty of a Class B misdemeanor.

Where married persons maintain and reside in separate residences qualifying as homestead property, each residence shall receive 50% of the total reduction in equalized assessed valuation provided by this Section.

In all counties, the assessor or chief county assessment officer may determine the eligibility of residential property to receive the homestead exemption and the amount of the exemption by application, visual inspection, questionnaire or other reasonable methods. The determination shall be made in accordance with guidelines established by the Department, provided that the taxpayer applying for an additional general exemption under this Section shall submit to the chief county assessment officer an application with an affidavit of the applicant's total household income, age, marital status (and, if married, the name and address of the applicant's spouse, if known), and principal dwelling place of members of the

household on January 1 of the taxable year. The Department shall issue guidelines establishing a method for verifying the accuracy of the affidavits filed by applicants under this paragraph. The applications shall be clearly marked as applications for the Additional General Homestead Exemption.

In counties with fewer than 3,000,000 inhabitants, in the event of a sale of homestead property the homestead exemption shall remain in effect for the remainder of the assessment year of the sale. The assessor or chief county assessment officer may require the new owner of the property to apply for the homestead exemption for the following assessment year.

Notwithstanding Sections 6 and 8 of the State Mandates Act, no reimbursement by the State is required for the implementation of any mandate created by this Section.

(Source: P.A. 95-644, eff. 10-12-07.)

(35 ILCS 200/20-15)

Sec. 20-15. Information on bill or separate statement. There shall be printed on each bill, or on a separate slip which shall be mailed with the bill:

(a) a statement itemizing the rate at which taxes have been extended for each of the taxing districts in the county in whose district the property is located, and in those counties utilizing electronic data processing equipment the dollar amount of tax due from the person assessed allocable to each of those taxing districts,

including a separate statement of the dollar amount of tax due which is allocable to a tax levied under the Illinois Local Library Act or to any other tax levied by a municipality or township for public library purposes,

(b) a separate statement for each of the taxing districts of the dollar amount of tax due which is allocable to a tax levied under the Illinois Pension Code or to any other tax levied by a municipality or township for public pension or retirement purposes,

(c) the total tax rate,

(d) the total amount of tax due, and

(e) the amount by which the total tax and the tax allocable to each taxing district differs from the taxpayer's last prior tax bill.

The county treasurer shall ensure that only those taxing districts in which a parcel of property is located shall be listed on the bill for that property.

In all counties the statement shall also provide:

(1) the property index number or other suitable description,

(2) the assessment of the property,

(3) the equalization factors imposed by the county and by the Department, and

(4) the equalized assessment resulting from the application of the equalization factors to the basic assessment.

In all counties which do not classify property for purposes of taxation, for property on which a single family residence is situated the statement shall also include a statement to reflect the fair cash value determined for the property. In all counties which classify property for purposes of taxation in accordance with Section 4 of Article IX of the Illinois Constitution, for parcels of residential property in the lowest assessment classification the statement shall also include a statement to reflect the fair cash value determined for the property.

In all counties, the statement must include information that certain taxpayers may be eligible for tax exemptions, abatements, and other assistance programs and that, for more information, taxpayers should consult with the office of their township or county assessor and with the Illinois Department of Revenue.

In all counties, the statement shall include information that certain taxpayers may be eligible for the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act and that applications are available from the Illinois Department on Aging.

In counties which use the estimated or accelerated billing methods, these statements shall only be provided with the final installment of taxes due. The provisions of this Section create a mandatory statutory duty. They are not merely directory or discretionary. The failure or neglect of the collector to mail

the bill, or the failure of the taxpayer to receive the bill, shall not affect the validity of any tax, or the liability for the payment of any tax.

(Source: P.A. 95-644, eff. 10-12-07.)

(35 ILCS 200/21-27)

Sec. 21-27. Waiver of interest penalty.

(a) On the recommendation of the county treasurer, the county board may adopt a resolution under which an interest penalty for the delinquent payment of taxes for any year that otherwise would be imposed under Section 21-15, 21-20, or 21-25 shall be waived in the case of any person who meets all of the following criteria:

(1) The person is determined eligible for a grant under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act with respect to the taxes for that year.

(2) The person requests, in writing, on a form approved by the county treasurer, a waiver of the interest penalty, and the request is filed with the county treasurer on or before the first day of the month that an installment of taxes is due.

(3) The person pays the installment of taxes due, in full, on or before the third day of the month that the installment is due.

(4) The county treasurer approves the request for a

waiver.

(b) With respect to property that qualifies as a brownfield site under Section 58.2 of the Environmental Protection Act, the county board, upon the recommendation of the county treasurer, may adopt a resolution to waive an interest penalty for the delinquent payment of taxes for any year that otherwise would be imposed under Section 21-15, 21-20, or 21-25 if all of the following criteria are met:

(1) the property has delinquent taxes and an outstanding interest penalty and the amount of that interest penalty is so large as to, possibly, result in all of the taxes becoming uncollectible;

(2) the property is part of a redevelopment plan of a unit of local government and that unit of local government does not oppose the waiver of the interest penalty;

(3) the redevelopment of the property will benefit the public interest by remediating the brownfield contamination;

(4) the taxpayer delivers to the county treasurer (i) a written request for a waiver of the interest penalty, on a form approved by the county treasurer, and (ii) a copy of the redevelopment plan for the property;

(5) the taxpayer pays, in full, the amount of up to the amount of the first 2 installments of taxes due, to be held in escrow pending the approval of the waiver, and enters into an agreement with the county treasurer setting forth a

schedule for the payment of any remaining taxes due; and

(6) the county treasurer approves the request for a waiver.

(Source: P.A. 97-655, eff. 1-13-12.)

Section 925. The Mobile Home Local Services Tax Act is amended by changing Section 7 as follows:

(35 ILCS 515/7) (from Ch. 120, par. 1207)

Sec. 7. The local services tax for owners of mobile homes who (a) are actually residing in such mobile homes, (b) hold title to such mobile home as provided in the Illinois Vehicle Code, and (c) are 65 years of age or older or are disabled persons within the meaning of Section 3.14 of the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act" on the annual billing date shall be reduced to 80 percent of the tax provided for in Section 3 of this Act. Proof that a claimant has been issued an Illinois Disabled Person Identification Card stating that the claimant is under a Class 2 disability, as provided in Section 4A of the Illinois Identification Card Act, shall constitute proof that the person thereon named is a disabled person within the meaning of this Act. An application for reduction of the tax shall be filed with the county clerk by the individuals who are entitled to the reduction. If the application is filed after May 1, the reduction in tax shall begin with the next annual

bill. Application for the reduction in tax shall be done by submitting proof that the applicant has been issued an Illinois Disabled Person Identification Card designating the applicant's disability as a Class 2 disability, or by affidavit in substantially the following form:

APPLICATION FOR REDUCTION OF MOBILE HOME LOCAL SERVICES TAX

I hereby make application for a reduction to 80% of the total tax imposed under "An Act to provide for a local services tax on mobile homes".

(1) Senior Citizens

(a) I actually reside in the mobile home ....

(b) I hold title to the mobile home as provided in the Illinois Vehicle Code ....

(c) I reached the age of 65 on or before either January 1 (or July 1) of the year in which this statement is filed. My date of birth is: ...

(2) Disabled Persons

(a) I actually reside in the mobile home...

(b) I hold title to the mobile home as provided in the Illinois Vehicle Code ....

(c) I was totally disabled on ... and have remained disabled until the date of this application. My Social Security, Veterans, Railroad or Civil Service Total Disability Claim Number is ... The undersigned declares under the penalty of perjury that the above statements are true and correct.

Dated (insert date).

.....

Signature of owner

.....

(Address)

.....

(City) (State) (Zip)

Approved by:

.....

(Assessor)

This application shall be accompanied by a copy of the applicant's most recent application filed with the Illinois Department on Aging under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.

(Source: P.A. 96-804, eff. 1-1-10.)

Section 930. The Metropolitan Transit Authority Act is amended by changing Sections 51 and 52 as follows:

(70 ILCS 3605/51)

Sec. 51. Free services; eligibility.

(a) Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly and until subsection (b) is implemented, any fixed route public transportation services provided by, or under grant or purchase of service contracts

of, the Board shall be provided without charge to all senior citizens of the Metropolitan Region (as such term is defined in 70 ILCS 3615/1.03) aged 65 and older, under such conditions as shall be prescribed by the Board.

(b) Notwithstanding any law to the contrary, no later than 180 days following the effective date of this amendatory Act of the 96th General Assembly, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, the Board shall be provided without charge to senior citizens aged 65 and older who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such conditions as shall be prescribed by the Board. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section. Nothing in this Section shall relieve the Board from providing reduced fares as may be required by federal law.

(Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

(70 ILCS 3605/52)

Sec. 52. Transit services for disabled individuals. Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly, all fixed route public transportation

services provided by, or under grant or purchase of service contract of, the Board shall be provided without charge to all disabled persons who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such procedures as shall be prescribed by the Board. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section.

(Source: P.A. 95-906, eff. 8-26-08.)

Section 935. The Local Mass Transit District Act is amended by changing Sections 8.6 and 8.7 as follows:

(70 ILCS 3610/8.6)

Sec. 8.6. Free services; eligibility.

(a) Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly and until subsection (b) is implemented, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, every District shall be provided without charge to all senior citizens of the District aged 65 and older, under such conditions as shall be prescribed by the District.

(b) Notwithstanding any law to the contrary, no later than

180 days following the effective date of this amendatory Act of the 96th General Assembly, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, every District shall be provided without charge to senior citizens aged 65 and older who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such conditions as shall be prescribed by the District. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section. Nothing in this Section shall relieve the District from providing reduced fares as may be required by federal law.

(Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

(70 ILCS 3610/8.7)

Sec. 8.7. Transit services for disabled individuals. Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly, all fixed route public transportation services provided by, or under grant or purchase of service contract of, any District shall be provided without charge to all disabled persons who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior

Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such procedures as shall be prescribed by the District. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section.
(Source: P.A. 95-906, eff. 8-26-08.)

Section 940. The Regional Transportation Authority Act is amended by changing Sections 3A.15, 3A.16, 3B.14, and 3B.15 as follows:

(70 ILCS 3615/3A.15)

Sec. 3A.15. Free services; eligibility.

(a) Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly and until subsection (b) is implemented, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, the Suburban Bus Board shall be provided without charge to all senior citizens of the Metropolitan Region aged 65 and older, under such conditions as shall be prescribed by the Suburban Bus Board.

(b) Notwithstanding any law to the contrary, no later than 180 days following the effective date of this amendatory Act of the 96th General Assembly, any fixed route public

transportation services provided by, or under grant or purchase of service contracts of, the Suburban Bus Board shall be provided without charge to senior citizens aged 65 and older who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such conditions as shall be prescribed by the Suburban Bus Board. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section. Nothing in this Section shall relieve the Suburban Bus Board from providing reduced fares as may be required by federal law.

(Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

(70 ILCS 3615/3A.16)

Sec. 3A.16. Transit services for disabled individuals. Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly, all fixed route public transportation services provided by, or under grant or purchase of service contract of, the Suburban Bus Board shall be provided without charge to all disabled persons who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such procedures as shall

be prescribed by the Board. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section.
(Source: P.A. 95-906, eff. 8-26-08.)

(70 ILCS 3615/3B.14)

Sec. 3B.14. Free services; eligibility.

(a) Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly and until subsection (b) is implemented, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, the Commuter Rail Board shall be provided without charge to all senior citizens of the Metropolitan Region aged 65 and older, under such conditions as shall be prescribed by the Commuter Rail Board.

(b) Notwithstanding any law to the contrary, no later than 180 days following the effective date of this amendatory Act of the 96th General Assembly, any fixed route public transportation services provided by, or under grant or purchase of service contracts of, the Commuter Rail Board shall be provided without charge to senior citizens aged 65 and older who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~

~~Assistance~~ Act, under such conditions as shall be prescribed by the Commuter Rail Board. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section. Nothing in this Section shall relieve the Commuter Rail Board from providing reduced fares as may be required by federal law.

(Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

(70 ILCS 3615/3B.15)

Sec. 3B.15. Transit services for disabled individuals. Notwithstanding any law to the contrary, no later than 60 days following the effective date of this amendatory Act of the 95th General Assembly, all fixed route public transportation services provided by, or under grant or purchase of service contract of, the Commuter Rail Board shall be provided without charge to all disabled persons who meet the income eligibility limitation set forth in subsection (a-5) of Section 4 of the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under such procedures as shall be prescribed by the Board. The Department on Aging shall furnish all information reasonably necessary to determine eligibility, including updated lists of individuals who are eligible for services without charge under this Section.

(Source: P.A. 95-906, eff. 8-26-08.)

Section 945. The Senior Citizen Courses Act is amended by changing Section 1 as follows:

(110 ILCS 990/1) (from Ch. 144, par. 1801)

Sec. 1. Definitions. For the purposes of this Act:

(a) "Public institutions of higher education" means 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, and the public community colleges subject to the "Public Community College Act".

(b) "Credit Course" means any program of study for which public institutions of higher education award credit hours.

(c) "Senior citizen" means any person 65 years or older whose annual household income is less than the threshold amount provided in Section 4 of the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act", approved July 17, 1972, as amended.

(Source: P.A. 89-4, eff. 1-1-96.)

Section 950. The Citizens Utility Board Act is amended by changing Section 9 as follows:

(220 ILCS 10/9) (from Ch. 111 2/3, par. 909)

Sec. 9. Mailing procedure.

(1) As used in this Section:

(a) "Enclosure" means a card, leaflet, envelope or combination thereof furnished by the corporation under this Section.

(b) "Mailing" means any communication by a State agency, other than a mailing made under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, that is sent through the United States Postal Service to more than 50,000 persons within a 12-month period.

(c) "State agency" means any officer, department, board, commission, institution or entity of the executive or legislative branches of State government.

(2) To accomplish its powers and duties under Section 5 this Act, the corporation, subject to the following limitations, may prepare and furnish to any State agency an enclosure to be included with a mailing by that agency.

(a) A State agency furnished with an enclosure shall include the enclosure within the mailing designated by the corporation.

(b) An enclosure furnished by the corporation under this Section shall be provided to the State agency a reasonable period of time in advance of the mailing.

(c) An enclosure furnished by the corporation under this Section shall be limited to informing the reader of the purpose, nature and activities of the corporation as

set forth in this Act and informing the reader that it may become a member in the corporation, maintain membership in the corporation and contribute money to the corporation directly.

(d) Prior to furnishing an enclosure to the State agency, the corporation shall seek and obtain approval of the content of the enclosure from the Illinois Commerce Commission. The Commission shall approve the enclosure if it determines that the enclosure (i) is not false or misleading and (ii) satisfies the requirements of this Act. The Commission shall be deemed to have approved the enclosure unless it disapproves the enclosure within 14 days from the date of receipt.

(3) The corporation shall reimburse each State agency for all reasonable incremental costs incurred by the State agency in complying with this Section above the agency's normal mailing and handling costs, provided that:

(a) The State agency shall first furnish the corporation with an itemized accounting of such additional cost; and

(b) The corporation shall not be required to reimburse the State agency for postage costs if the weight of the corporation's enclosure does not exceed .35 ounce avoirdupois. If the corporation's enclosure exceeds that weight, then it shall only be required to reimburse the State agency for postage cost over and above what the

agency's postage cost would have been had the enclosure weighed only .35 ounce avoirdupois.

(Source: P.A. 96-804, eff. 1-1-10.)

Section 955. The Illinois Public Aid Code is amended by changing Sections 3-5, 4-1.6, 4-2, 6-1.2, 6-2, and 12-9 as follows:

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

Sec. 3-5. Amount of aid. The amount and nature of financial aid granted to or in behalf of aged, blind, or disabled persons shall be determined in accordance with the standards, grant amounts, rules and regulations of the Illinois Department. Due regard shall be given to the requirements and conditions existing in each case, and to the amount of property owned and the income, money contributions, and other support, and resources received or obtainable by the person, from whatever source. However, the amount and nature of any financial aid is not affected by the payment of any grant under the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The aid shall be sufficient, when added to all other income, money contributions and support, to provide the person with a grant in the amount established by Department regulation for

such a person, based upon standards providing a livelihood compatible with health and well-being. Financial aid under this Article granted to persons who have been found ineligible for Supplemental Security Income (SSI) due to expiration of the period of eligibility for refugees and asylees pursuant to 8 U.S.C. 1612(a)(2) shall not exceed $500 per month.

(Source: P.A. 93-741, eff. 7-15-04.)

(305 ILCS 5/4-1.6) (from Ch. 23, par. 4-1.6)

Sec. 4-1.6. Need. Income available to the family as defined by the Illinois Department by rule, or to the child in the case of a child removed from his or her home, when added to contributions in money, substance or services from other sources, including income available from parents absent from the home or from a stepparent, contributions made for the benefit of the parent or other persons necessary to provide care and supervision to the child, and contributions from legally responsible relatives, must be equal to or less than the grant amount established by Department regulation for such a person. For purposes of eligibility for aid under this Article, the Department shall disregard all earned income between the grant amount and 50% of the Federal Poverty Level.

In considering income to be taken into account, consideration shall be given to any expenses reasonably attributable to the earning of such income. Three-fourths of the earned income of a household eligible for aid under this

Article shall be disregarded when determining the level of assistance for which a household is eligible. The Illinois Department may also permit all or any portion of earned or other income to be set aside for the future identifiable needs of a child. The Illinois Department may provide by rule and regulation for the exemptions thus permitted or required. The eligibility of any applicant for or recipient of public aid under this Article is not affected by the payment of any grant under the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

The Illinois Department may, by rule, set forth criteria under which an assistance unit is ineligible for cash assistance under this Article for a specified number of months due to the receipt of a lump sum payment.

(Source: P.A. 96-866, eff. 7-1-10.)

(305 ILCS 5/4-2) (from Ch. 23, par. 4-2)

Sec. 4-2. Amount of aid.

(a) The amount and nature of financial aid shall be determined in accordance with the grant amounts, rules and regulations of the Illinois Department. Due regard shall be given to the self-sufficiency requirements of the family and to the income, money contributions and other support and resources

available, from whatever source. However, the amount and nature of any financial aid is not affected by the payment of any grant under the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The aid shall be sufficient, when added to all other income, money contributions and support to provide the family with a grant in the amount established by Department regulation.

Subject to appropriation, beginning on July 1, 2008, the Department of Human Services shall increase TANF grant amounts in effect on June 30, 2008 by 15%. The Department is authorized to administer this increase but may not otherwise adopt any rule to implement this increase.

(b) The Illinois Department may conduct special projects, which may be known as Grant Diversion Projects, under which recipients of financial aid under this Article are placed in jobs and their grants are diverted to the employer who in turn makes payments to the recipients in the form of salary or other employment benefits. The Illinois Department shall by rule specify the terms and conditions of such Grant Diversion Projects. Such projects shall take into consideration and be coordinated with the programs administered under the Illinois Emergency Employment Development Act.

(c) The amount and nature of the financial aid for a child

requiring care outside his own home shall be determined in accordance with the rules and regulations of the Illinois Department, with due regard to the needs and requirements of the child in the foster home or institution in which he has been placed.

(d) If the Department establishes grants for family units consisting exclusively of a pregnant woman with no dependent child or including her husband if living with her, the grant amount for such a unit shall be equal to the grant amount for an assistance unit consisting of one adult, or 2 persons if the husband is included. Other than as herein described, an unborn child shall not be counted in determining the size of an assistance unit or for calculating grants.

Payments for basic maintenance requirements of a child or children and the relative with whom the child or children are living shall be prescribed, by rule, by the Illinois Department.

Grants under this Article shall not be supplemented by General Assistance provided under Article VI.

(e) Grants shall be paid to the parent or other person with whom the child or children are living, except for such amount as is paid in behalf of the child or his parent or other relative to other persons or agencies pursuant to this Code or the rules and regulations of the Illinois Department.

(f) Subject to subsection (f-5), an assistance unit, receiving financial aid under this Article or temporarily

ineligible to receive aid under this Article under a penalty imposed by the Illinois Department for failure to comply with the eligibility requirements or that voluntarily requests termination of financial assistance under this Article and becomes subsequently eligible for assistance within 9 months, shall not receive any increase in the amount of aid solely on account of the birth of a child; except that an increase is not prohibited when the birth is (i) of a child of a pregnant woman who became eligible for aid under this Article during the pregnancy, or (ii) of a child born within 10 months after the date of implementation of this subsection, or (iii) of a child conceived after a family became ineligible for assistance due to income or marriage and at least 3 months of ineligibility expired before any reapplication for assistance. This subsection does not, however, prevent a unit from receiving a general increase in the amount of aid that is provided to all recipients of aid under this Article.

The Illinois Department is authorized to transfer funds, and shall use any budgetary savings attributable to not increasing the grants due to the births of additional children, to supplement existing funding for employment and training services for recipients of aid under this Article IV. The Illinois Department shall target, to the extent the supplemental funding allows, employment and training services to the families who do not receive a grant increase after the birth of a child. In addition, the Illinois Department shall

provide, to the extent the supplemental funding allows, such families with up to 24 months of transitional child care pursuant to Illinois Department rules. All remaining supplemental funds shall be used for employment and training services or transitional child care support.

In making the transfers authorized by this subsection, the Illinois Department shall first determine, pursuant to regulations adopted by the Illinois Department for this purpose, the amount of savings attributable to not increasing the grants due to the births of additional children. Transfers may be made from General Revenue Fund appropriations for distributive purposes authorized by Article IV of this Code only to General Revenue Fund appropriations for employability development services including operating and administrative costs and related distributive purposes under Article IXA of this Code. The Director, with the approval of the Governor, shall certify the amount and affected line item appropriations to the State Comptroller.

Nothing in this subsection shall be construed to prohibit the Illinois Department from using funds under this Article IV to provide assistance in the form of vouchers that may be used to pay for goods and services deemed by the Illinois Department, by rule, as suitable for the care of the child such as diapers, clothing, school supplies, and cribs.

(f-5) Subsection (f) shall not apply to affect the monthly assistance amount of any family as a result of the birth of a

child on or after January 1, 2004. As resources permit after January 1, 2004, the Department may cease applying subsection (f) to limit assistance to families receiving assistance under this Article on January 1, 2004, with respect to children born prior to that date. In any event, subsection (f) shall be completely inoperative on and after July 1, 2007.

(g) (Blank).

(h) Notwithstanding any other provision of this Code, the Illinois Department is authorized to reduce payment levels used to determine cash grants under this Article after December 31 of any fiscal year if the Illinois Department determines that the caseload upon which the appropriations for the current fiscal year are based have increased by more than 5% and the appropriation is not sufficient to ensure that cash benefits under this Article do not exceed the amounts appropriated for those cash benefits. Reductions in payment levels may be accomplished by emergency rule under Section 5-45 of the Illinois Administrative Procedure Act, except that the limitation on the number of emergency rules that may be adopted in a 24-month period shall not apply and the provisions of Sections 5-115 and 5-125 of the Illinois Administrative Procedure Act shall not apply. Increases in payment levels shall be accomplished only in accordance with Section 5-40 of the Illinois Administrative Procedure Act. Before any rule to increase payment levels promulgated under this Section shall become effective, a joint resolution approving the rule must be

adopted by a roll call vote by a majority of the members elected to each chamber of the General Assembly.

(Source: P.A. 95-744, eff. 7-18-08; 95-1055, eff. 4-10-09; 96-1000, eff. 7-2-10.)

(305 ILCS 5/6-1.2) (from Ch. 23, par. 6-1.2)

Sec. 6-1.2. Need. Income available to the person, when added to contributions in money, substance, or services from other sources, including contributions from legally responsible relatives, must be insufficient to equal the grant amount established by Department regulation (or by local governmental unit in units which do not receive State funds) for such a person.

In determining income to be taken into account:

(1) The first $75 of earned income in income assistance units comprised exclusively of one adult person shall be disregarded, and for not more than 3 months in any 12 consecutive months that portion of earned income beyond the first $75 that is the difference between the standard of assistance and the grant amount, shall be disregarded.

(2) For income assistance units not comprised exclusively of one adult person, when authorized by rules and regulations of the Illinois Department, a portion of earned income, not to exceed the first $25 a month plus 50% of the next $75, may be disregarded for the purpose of stimulating and aiding rehabilitative effort and

self-support activity.

"Earned income" means money earned in self-employment or wages, salary, or commission for personal services performed as an employee. The eligibility of any applicant for or recipient of public aid under this Article is not affected by the payment of any grant under the "Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act", any refund or payment of the federal Earned Income Tax Credit, or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

(Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

(305 ILCS 5/6-2) (from Ch. 23, par. 6-2)

Sec. 6-2. Amount of aid. The amount and nature of General Assistance for basic maintenance requirements shall be determined in accordance with local budget standards for local governmental units which do not receive State funds. For local governmental units which do receive State funds, the amount and nature of General Assistance for basic maintenance requirements shall be determined in accordance with the standards, rules and regulations of the Illinois Department. However, the amount and nature of any financial aid is not affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or any distributions or items of income

described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. Due regard shall be given to the requirements and the conditions existing in each case, and to the income, money contributions and other support and resources available, from whatever source. In local governmental units which do not receive State funds, the grant shall be sufficient when added to all other income, money contributions and support in excess of any excluded income or resources, to provide the person with a grant in the amount established for such a person by the local governmental unit based upon standards meeting basic maintenance requirements. In local governmental units which do receive State funds, the grant shall be sufficient when added to all other income, money contributions and support in excess of any excluded income or resources, to provide the person with a grant in the amount established for such a person by Department regulation based upon standards providing a livelihood compatible with health and well-being, as directed by Section 12-4.11 of this Code.

The Illinois Department may conduct special projects, which may be known as Grant Diversion Projects, under which recipients of financial aid under this Article are placed in jobs and their grants are diverted to the employer who in turn makes payments to the recipients in the form of salary or other employment benefits. The Illinois Department shall by rule specify the terms and conditions of such Grant Diversion Projects. Such projects shall take into consideration and be

coordinated with the programs administered under the Illinois Emergency Employment Development Act.

The allowances provided under Article IX for recipients participating in the training and rehabilitation programs shall be in addition to such maximum payment.

Payments may also be made to provide persons receiving basic maintenance support with necessary treatment, care and supplies required because of illness or disability or with acute medical treatment, care, and supplies. Payments for necessary or acute medical care under this paragraph may be made to or in behalf of the person. Obligations incurred for such services but not paid for at the time of a recipient's death may be paid, subject to the rules and regulations of the Illinois Department, after the death of the recipient.

(Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

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

Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The Public Aid Recoveries Trust Fund shall consist of (1) recoveries by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) authorized by this Code in respect to applicants or recipients under Articles III, IV, V, and VI, including recoveries made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) from the estates of deceased recipients, (2) recoveries made by the Department of Healthcare and Family

Services (formerly Illinois Department of Public Aid) in respect to applicants and recipients under the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, ~~and the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act,~~ (3) federal funds received on behalf of and earned by State universities and local governmental entities for services provided to applicants or recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, ~~and the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act,~~ (3.5) federal financial participation revenue related to eligible disbursements made by the Department of Healthcare and Family Services from appropriations required by this Section, and (4) all other moneys received to the Fund, including interest thereon. The Fund shall be held as a special fund in the State Treasury.

Disbursements from this Fund shall be only (1) for the reimbursement of claims collected by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) through error or mistake, (2) for payment to persons or agencies designated as payees or co-payees on any instrument, whether or not negotiable, delivered to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) as a recovery under this Section, such payment to be in proportion to the respective

interests of the payees in the amount so collected, (3) for payments to the Department of Human Services for collections made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) on behalf of the Department of Human Services under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (4) for payment of administrative expenses incurred in performing the activities authorized under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, ~~and the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act,~~ (5) for payment of fees to persons or agencies in the performance of activities pursuant to the collection of monies owed the State that are collected under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, ~~and the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act,~~ (6) for payments of any amounts which are reimbursable to the federal government which are required to be paid by State warrant by either the State or federal government, and (7) for payments to State universities and local governmental entities of federal funds for services provided to applicants or recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act~~, and the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act~~.

Disbursements from this Fund for purposes of items (4) and (5) of this paragraph shall be subject to appropriations from the Fund to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid).

The balance in this Fund on the first day of each calendar quarter, after payment therefrom of any amounts reimbursable to the federal government, and minus the amount reasonably anticipated to be needed to make the disbursements during that quarter authorized by this Section, shall be certified by the Director of Healthcare and Family Services and transferred by the State Comptroller to the Drug Rebate Fund or the Healthcare Provider Relief Fund in the State Treasury, as appropriate, within 30 days of the first day of each calendar quarter. The Director of Healthcare and Family Services may certify and the State Comptroller shall transfer to the Drug Rebate Fund amounts on a more frequent basis.

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

(Source: P.A. 96-1100, eff. 1-1-11; 97-647, eff. 1-1-12.)

Section 960. The Senior Citizens Real Estate Tax Deferral Act is amended by changing Sections 2 and 8 as follows:

(320 ILCS 30/2) (from Ch. 67 1/2, par. 452)

Sec. 2. Definitions. As used in this Act:

(a) "Taxpayer" means an individual whose household income for the year is no greater than: (i) $40,000 through tax year 2005; (ii) $50,000 for tax years 2006 through 2011; and (iii) $55,000 for tax year 2012 and thereafter.

(b) "Tax deferred property" means the property upon which real estate taxes are deferred under this Act.

(c) "Homestead" means the land and buildings thereon, including a condominium or a dwelling unit in a multidwelling building that is owned and operated as a cooperative, occupied by the taxpayer as his residence or which are temporarily unoccupied by the taxpayer because such taxpayer is temporarily residing, for not more than 1 year, in a licensed facility as defined in Section 1-113 of the Nursing Home Care Act.

(d) "Real estate taxes" or "taxes" means the taxes on real property for which the taxpayer would be liable under the Property Tax Code, including special service area taxes, and special assessments on benefited real property for which the taxpayer would be liable to a unit of local government.

(e) "Department" means the Department of Revenue.

(f) "Qualifying property" means a homestead which (a) the taxpayer or the taxpayer and his spouse own in fee simple or are purchasing in fee simple under a recorded instrument of sale, (b) is not income-producing property, (c) is not subject to a lien for unpaid real estate taxes when a claim under this Act is filed, and (d) is not held in trust, other than an

Illinois land trust with the taxpayer identified as the sole beneficiary, if the taxpayer is filing for the program for the first time effective as of the January 1, 2011 assessment year or tax year 2012 and thereafter.

(g) "Equity interest" means the current assessed valuation of the qualified property times the fraction necessary to convert that figure to full market value minus any outstanding debts or liens on that property. In the case of qualifying property not having a separate assessed valuation, the appraised value as determined by a qualified real estate appraiser shall be used instead of the current assessed valuation.

(h) "Household income" has the meaning ascribed to that term in the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.

(i) "Collector" means the county collector or, if the taxes to be deferred are special assessments, an official designated by a unit of local government to collect special assessments.

(Source: P.A. 97-481, eff. 8-22-11.)

(320 ILCS 30/8) (from Ch. 67 1/2, par. 458)

Sec. 8. Nothing in this Act (a) affects any provision of any mortgage or other instrument relating to land requiring a person to pay real estate taxes or (b) affects the eligibility of any person to receive any grant pursuant to the "Senior Citizens and Disabled Persons Property Tax Relief ~~and~~

~~Pharmaceutical Assistance~~ Act".

(Source: P.A. 84-807; 84-832.)

Section 965. The Senior Pharmaceutical Assistance Act is amended by changing Section 5 as follows:

(320 ILCS 50/5)

Sec. 5. Findings. The General Assembly finds:

(1) Senior citizens identify pharmaceutical assistance as the single most critical factor to their health, well-being, and continued independence.

(2) The State of Illinois currently operates 2 pharmaceutical assistance programs that benefit seniors: (i) the program of pharmaceutical assistance under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act and (ii) the Aid to the Aged, Blind, or Disabled program under the Illinois Public Aid Code. The State has been given authority to establish a third program, SeniorRx Care, through a federal Medicaid waiver.

(3) Each year, numerous pieces of legislation are filed seeking to establish additional pharmaceutical assistance benefits for seniors or to make changes to the existing programs.

(4) Establishment of a pharmaceutical assistance review committee will ensure proper coordination of benefits, diminish the likelihood of duplicative benefits, and ensure

that the best interests of seniors are served.

(5) In addition to the State pharmaceutical assistance programs, several private entities, such as drug manufacturers and pharmacies, also offer prescription drug discount or coverage programs.

(6) Many seniors are unaware of the myriad of public and private programs available to them.

(7) Establishing a pharmaceutical clearinghouse with a toll-free hot-line and local outreach workers will educate seniors about the vast array of options available to them and enable seniors to make an educated and informed choice that is best for them.

(8) Estimates indicate that almost one-third of senior citizens lack prescription drug coverage. The federal government, states, and the pharmaceutical industry each have a role in helping these uninsured seniors gain access to life-saving medications.

(9) The State of Illinois has recognized its obligation to assist Illinois' neediest seniors in purchasing prescription medications, and it is now time for pharmaceutical manufacturers to recognize their obligation to make their medications affordable to seniors.

(Source: P.A. 92-594, eff. 6-27-02.)

Section 970. The Illinois Vehicle Code is amended by changing Sections 3-609, 3-623, 3-626, 3-667, 3-683, 3-806.3,

and 11-1301.2 as follows:

(625 ILCS 5/3-609) (from Ch. 95 1/2, par. 3-609)

Sec. 3-609. Disabled Veterans' Plates. Any veteran may make application for the registration of one motor vehicle of the first division or one motor vehicle of the second division weighing not more than 8,000 pounds to the Secretary of State without the payment of any registration fee if (i) the veteran holds proof of a service-connected disability from the United States Department of Veterans Affairs and (ii) a licensed physician, physician assistant, or advanced practice nurse has certified in accordance with Section 3-616 that because of the service-connected disability the veteran qualifies for issuance of registration plates or decals to a person with disabilities. The Secretary may, in his or her discretion, allow the plates to be issued as vanity or personalized plates in accordance with Section 3-405.1 of this Code. Registration shall be for a multi-year period and may be issued staggered registration.

Renewal of such registration must be accompanied with documentation for eligibility of registration without fee unless the applicant has a permanent qualifying disability, and such registration plates may not be issued to any person not eligible therefor.

The Illinois Department of Veterans' Affairs may assist in providing the documentation of disability.

Commencing with the 2009 registration year, any person eligible to receive license plates under this Section who has been approved for benefits under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, or who has claimed and received a grant under that Act, shall pay a fee of $24 instead of the fee otherwise provided in this Code for passenger cars displaying standard multi-year registration plates issued under Section 3-414.1, for motor vehicles registered at 8,000 pounds or less under Section 3-815(a), or for recreational vehicles registered at 8,000 pounds or less under Section 3-815(b), for a second set of plates under this Section.

(Source: P.A. 95-157, eff. 1-1-08; 95-167, eff. 1-1-08; 95-353, eff. 1-1-08; 95-876, eff. 8-21-08; 96-79, eff. 1-1-10.)

(625 ILCS 5/3-623) (from Ch. 95 1/2, par. 3-623)

Sec. 3-623. Purple Heart Plates. The Secretary, upon receipt of an application made in the form prescribed by the Secretary of State, may issue to recipients awarded the Purple Heart by a branch of the armed forces of the United States who reside in Illinois, special registration plates. The Secretary, upon receipt of the proper application, may also issue these special registration plates to an Illinois resident who is the surviving spouse of a person who was awarded the Purple Heart by a branch of the armed forces of the United States. The special plates issued pursuant to this Section

should be affixed only to passenger vehicles of the 1st division, including motorcycles, or motor vehicles of the 2nd division weighing not more than 8,000 pounds. The Secretary may, in his or her discretion, allow the plates to be issued as vanity or personalized plates in accordance with Section 3-405.1 of this Code. The Secretary of State must make a version of the special registration plates authorized under this Section in a form appropriate for motorcycles.

The design and color of such plates shall be wholly within the discretion of the Secretary of State. Appropriate documentation, as determined by the Secretary, and the appropriate registration fee shall accompany the application. However, for an individual who has been issued Purple Heart plates for a vehicle and who has been approved for benefits under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, the annual fee for the registration of the vehicle shall be as provided in Section 3-806.3 of this Code.

(Source: P.A. 95-331, eff. 8-21-07; 95-353, eff. 1-1-08; 96-1101, eff. 1-1-11.)

(625 ILCS 5/3-626)

Sec. 3-626. Korean War Veteran license plates.

(a) In addition to any other special license plate, the Secretary, upon receipt of all applicable fees and applications made in the form prescribed by the Secretary of State, may

issue special registration plates designated as Korean War Veteran license plates to residents of Illinois who participated in the United States Armed Forces during the Korean War. The special plate issued under this Section shall be affixed only to passenger vehicles of the first division, motorcycles, motor vehicles of the second division weighing not more than 8,000 pounds, and recreational vehicles as defined by Section 1-169 of this Code. Plates issued under this Section shall expire according to the staggered multi-year procedure established by Section 3-414.1 of this Code.

(b) The design, color, and format of the plates shall be wholly within the discretion of the Secretary of State. The Secretary may, in his or her discretion, allow the plates to be issued as vanity plates or personalized in accordance with Section 3-405.1 of this Code. The plates are not required to designate "Land Of Lincoln", as prescribed in subsection (b) of Section 3-412 of this Code. The Secretary shall prescribe the eligibility requirements and, in his or her discretion, shall approve and prescribe stickers or decals as provided under Section 3-412.

(c) (Blank).

(d) The Korean War Memorial Construction Fund is created as a special fund in the State treasury. All moneys in the Korean War Memorial Construction Fund shall, subject to appropriation, be used by the Department of Veteran Affairs to provide grants for construction of the Korean War Memorial to

be located at Oak Ridge Cemetery in Springfield, Illinois. Upon the completion of the Memorial, the Department of Veteran Affairs shall certify to the State Treasurer that the construction of the Memorial has been completed. Upon the certification by the Department of Veteran Affairs, the State Treasurer shall transfer all moneys in the Fund and any future deposits into the Fund into the Secretary of State Special License Plate Fund.

(e) An individual who has been issued Korean War Veteran license plates for a vehicle and who has been approved for benefits under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay the original issuance and the regular annual fee for the registration of the vehicle as provided in Section 3-806.3 of this Code in addition to the fees specified in subsection (c) of this Section.

(Source: P.A. 96-1409, eff. 1-1-11.)

(625 ILCS 5/3-667)

Sec. 3-667. Korean Service license plates.

(a) In addition to any other special license plate, the Secretary, upon receipt of all applicable fees and applications made in the form prescribed by the Secretary of State, may issue special registration plates designated as Korean Service license plates to residents of Illinois who, on or after July 27, 1954, participated in the United States Armed Forces in

Korea. The special plate issued under this Section shall be affixed only to passenger vehicles of the first division, motorcycles, motor vehicles of the second division weighing not more than 8,000 pounds, and recreational vehicles as defined by Section 1-169 of this Code. Plates issued under this Section shall expire according to the staggered multi-year procedure established by Section 3-414.1 of this Code.

(b) The design, color, and format of the plates shall be wholly within the discretion of the Secretary of State. The Secretary may, in his or her discretion, allow the plates to be issued as vanity or personalized plates in accordance with Section 3-405.1 of this Code. The plates are not required to designate "Land of Lincoln", as prescribed in subsection (b) of Section 3-412 of this Code. The Secretary shall prescribe the eligibility requirements and, in his or her discretion, shall approve and prescribe stickers or decals as provided under Section 3-412.

(c) An applicant shall be charged a $2 fee for original issuance in addition to the applicable registration fee. This additional fee shall be deposited into the Korean War Memorial Construction Fund a special fund in the State treasury.

(d) An individual who has been issued Korean Service license plates for a vehicle and who has been approved for benefits under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay the original issuance and the regular annual fee for the

registration of the vehicle as provided in Section 3-806.3 of this Code in addition to the fees specified in subsection (c) of this Section.

(Source: P.A. 97-306, eff. 1-1-12.)

(625 ILCS 5/3-683)

Sec. 3-683. Distinguished Service Cross license plates. The Secretary, upon receipt of an application made in the form prescribed by the Secretary of State, shall issue special registration plates to any Illinois resident who has been awarded the Distinguished Service Cross by a branch of the armed forces of the United States. The Secretary, upon receipt of the proper application, shall also issue these special registration plates to an Illinois resident who is the surviving spouse of a person who was awarded the Distinguished Service Cross by a branch of the armed forces of the United States. The special plates issued under this Section should be affixed only to passenger vehicles of the first division, including motorcycles, or motor vehicles of the second division weighing not more than 8,000 pounds.

The design and color of the plates shall be wholly within the discretion of the Secretary of State. Appropriate documentation, as determined by the Secretary, and the appropriate registration fee shall accompany the application. However, for an individual who has been issued Distinguished Service Cross plates for a vehicle and who has been approved

for benefits under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, the annual fee for the registration of the vehicle shall be as provided in Section 3-806.3 of this Code.

(Source: P.A. 95-794, eff. 1-1-09; 96-328, eff. 8-11-09.)

(625 ILCS 5/3-806.3) (from Ch. 95 1/2, par. 3-806.3)

Sec. 3-806.3. Senior Citizens. Commencing with the 2009 registration year, the registration fee paid by any vehicle owner who has been approved for benefits under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or who is the spouse of such a person shall be $24 instead of the fee otherwise provided in this Code for passenger cars displaying standard multi-year registration plates issued under Section 3-414.1, motor vehicles displaying special registration plates issued under Section 3-609, 3-616, 3-621, 3-622, 3-623, 3-624, 3-625, 3-626, 3-628, 3-638, 3-642, 3-645, 3-647, 3-650, 3-651, or 3-663, motor vehicles registered at 8,000 pounds or less under Section 3-815(a), and recreational vehicles registered at 8,000 pounds or less under Section 3-815(b). Widows and widowers of claimants shall also be entitled to this reduced registration fee for the registration year in which the claimant was eligible.

Commencing with the 2009 registration year, the registration fee paid by any vehicle owner who has claimed and

received a grant under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or who is the spouse of such a person shall be $24 instead of the fee otherwise provided in this Code for passenger cars displaying standard multi-year registration plates issued under Section 3-414.1, motor vehicles displaying special registration plates issued under Section 3-607, 3-609, 3-616, 3-621, 3-622, 3-623, 3-624, 3-625, 3-626, 3-628, 3-638, 3-642, 3-645, 3-647, 3-650, 3-651, 3-663, or 3-664, motor vehicles registered at 8,000 pounds or less under Section 3-815(a), and recreational vehicles registered at 8,000 pounds or less under Section 3-815(b). Widows and widowers of claimants shall also be entitled to this reduced registration fee for the registration year in which the claimant was eligible.

No more than one reduced registration fee under this Section shall be allowed during any 12 month period based on the primary eligibility of any individual, whether such reduced registration fee is allowed to the individual or to the spouse, widow or widower of such individual. This Section does not apply to the fee paid in addition to the registration fee for motor vehicles displaying vanity or special license plates.

(Source: P.A. 95-157, eff. 1-1-08; 95-331, eff. 8-21-07; 95-876, eff. 8-21-08; 96-554, eff. 1-1-10.)

(625 ILCS 5/11-1301.2) (from Ch. 95 1/2, par. 11-1301.2)

Sec. 11-1301.2. Special decals for parking; persons with

disabilities.

(a) The Secretary of State shall provide for, by administrative rules, the design, size, color, and placement of a person with disabilities motorist decal or device and shall provide for, by administrative rules, the content and form of an application for a person with disabilities motorist decal or device, which shall be used by local authorities in the issuance thereof to a person with temporary disabilities, provided that the decal or device is valid for no more than 90 days, subject to renewal for like periods based upon continued disability, and further provided that the decal or device clearly sets forth the date that the decal or device expires. The application shall include the requirement of an Illinois Identification Card number or a State of Illinois driver's license number. This decal or device may be used by the authorized holder to designate and identify a vehicle not owned or displaying a registration plate as provided in Sections 3-609 and 3-616 of this Act to designate when the vehicle is being used to transport said person or persons with disabilities, and thus is entitled to enjoy all the privileges that would be afforded a person with disabilities licensed vehicle. Person with disabilities decals or devices issued and displayed pursuant to this Section shall be recognized and honored by all local authorities regardless of which local authority issued such decal or device.

The decal or device shall be issued only upon a showing by

adequate documentation that the person for whose benefit the decal or device is to be used has a temporary disability as defined in Section 1-159.1 of this Code.

(b) The local governing authorities shall be responsible for the provision of such decal or device, its issuance and designated placement within the vehicle. The cost of such decal or device shall be at the discretion of such local governing authority.

(c) The Secretary of State may, pursuant to Section 3-616(c), issue a person with disabilities parking decal or device to a person with disabilities as defined by Section 1-159.1. Any person with disabilities parking decal or device issued by the Secretary of State shall be registered to that person with disabilities in the form to be prescribed by the Secretary of State. The person with disabilities parking decal or device shall not display that person's address. One additional decal or device may be issued to an applicant upon his or her written request and with the approval of the Secretary of State. The written request must include a justification of the need for the additional decal or device.

(d) Replacement decals or devices may be issued for lost, stolen, or destroyed decals upon application and payment of a $10 fee. The replacement fee may be waived for individuals that have claimed and received a grant under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.

(Source: P.A. 95-167, eff. 1-1-08; 96-72, eff. 1-1-10; 96-79, eff. 1-1-10; 96-1000, eff. 7-2-10.)

Section 975. The Criminal Code of 1961 is amended by changing Section 17-6.5 as follows:

(720 ILCS 5/17-6.5)

Sec. 17-6.5. Persons under deportation order; ineligibility for benefits.

(a) An individual against whom a United States Immigration Judge has issued an order of deportation which has been affirmed by the Board of Immigration Review, as well as an individual who appeals such an order pending appeal, under paragraph 19 of Section 241(a) of the Immigration and Nationality Act relating to persecution of others on account of race, religion, national origin or political opinion under the direction of or in association with the Nazi government of Germany or its allies, shall be ineligible for the following benefits authorized by State law:

(1) The homestead exemptions and homestead improvement exemption under Sections 15-170, 15-175, 15-176, and 15-180 of the Property Tax Code.

(2) Grants under the Senior Citizens and Disabled Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.

(3) The double income tax exemption conferred upon

persons 65 years of age or older by Section 204 of the Illinois Income Tax Act.

(4) Grants provided by the Department on Aging.

(5) Reductions in vehicle registration fees under Section 3-806.3 of the Illinois Vehicle Code.

(6) Free fishing and reduced fishing license fees under Sections 20-5 and 20-40 of the Fish and Aquatic Life Code.

(7) Tuition free courses for senior citizens under the Senior Citizen Courses Act.

(8) Any benefits under the Illinois Public Aid Code.

(b) If a person has been found by a court to have knowingly received benefits in violation of subsection (a) and:

(1) the total monetary value of the benefits received is less than $150, the person is guilty of a Class A misdemeanor; a second or subsequent violation is a Class 4 felony;

(2) the total monetary value of the benefits received is $150 or more but less than $1,000, the person is guilty of a Class 4 felony; a second or subsequent violation is a Class 3 felony;

(3) the total monetary value of the benefits received is $1,000 or more but less than $5,000, the person is guilty of a Class 3 felony; a second or subsequent violation is a Class 2 felony;

(4) the total monetary value of the benefits received is $5,000 or more but less than $10,000, the person is

guilty of a Class 2 felony; a second or subsequent violation is a Class 1 felony; or

(5) the total monetary value of the benefits received is $10,000 or more, the person is guilty of a Class 1 felony.

(c) For purposes of determining the classification of an offense under this Section, all of the monetary value of the benefits received as a result of the unlawful act, practice, or course of conduct may be accumulated.

(d) Any grants awarded to persons described in subsection (a) may be recovered by the State of Illinois in a civil action commenced by the Attorney General in the circuit court of Sangamon County or the State's Attorney of the county of residence of the person described in subsection (a).

(e) An individual described in subsection (a) who has been deported shall be restored to any benefits which that individual has been denied under State law pursuant to subsection (a) if (i) the Attorney General of the United States has issued an order cancelling deportation and has adjusted the status of the individual to that of an alien lawfully admitted for permanent residence in the United States or (ii) the country to which the individual has been deported adjudicates or exonerates the individual in a judicial or administrative proceeding as not being guilty of the persecution of others on account of race, religion, national origin, or political opinion under the direction of or in association with the Nazi

government of Germany or its allies.

(Source: P.A. 96-1551, eff. 7-1-11.)

Section 995. 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 999. Effective date. This Act takes effect upon becoming law, except that Sections 15, 20, 30, and 85 take effect on July 1, 2012.".