AN ACT concerning public aid.

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

Section 5. If and only if both Senate Bill 2840, AS AMENDED, of the 97th General Assembly and Senate Bill 3397, AS AMENDED, of the 97th General Assembly become law, then the Illinois Public Aid Code is amended by changing Sections 5-1.4, 5-2, 5-2.03, 15-1, 15-2, 15-5, and 15-11 as follows:

(305 ILCS 5/5-1.4)

Sec. 5-1.4. Moratorium on eligibility expansions. Beginning on January 25, 2011 (the effective date of Public Act 96-1501) ~~this amendatory Act of the 96th General Assembly~~, there shall be a 4-year ~~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 or above the level of any subsequent reduction in eligibility. 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 local government entity funding the expansion, pursuant to an intergovernmental agreement between the Department of Healthcare and Family Services and the local government entity. 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, 2015.

(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. 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) Through December 31, 2013, a caretaker relative who is 19 years of age or older when countable income is at or below 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) 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) Premiums shall be billed by and payable to the Department or its authorized agent, on a monthly basis.

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

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

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

(h) Partial premium payments shall not be refunded.

(i) Following termination of an individual's coverage under this paragraph 15, the 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 5/5-2.03)

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 5/15-1) (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; and~~.~~

(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 99. Effective date. This Act takes effect upon becoming law; however, no part of this Act takes effect until both Senate Bill 2840, AS AMENDED, of the 97th General Assembly and Senate Bill 3397, AS AMENDED, of the 97th General Assembly have become law.