AN ACT in relation to budget implementation.

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

Section 1. Short title. This Act may be cited as the FY2005 Budget Implementation (Human Services) Act.

Section 5. Purpose. It is the purpose of this Act to make changes in State programs that are necessary to implement the Governor's FY2005 budget recommendations concerning human services.

Section 7. 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 or (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act. 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.

(Source: P.A. 92-10, eff. 6-11-01; 92-597, eff. 6-28-02; 93-20, eff. 6-20-03.)

Section 10. The Mental Health and Developmental Disabilities Administrative Act is amended by changing Section 18.4 and adding Section 18.5 as follows:

(20 ILCS 1705/18.4)

Sec. 18.4. Community Mental Health Medicaid Trust Fund; reimbursement.

(a) The Community Mental Health Medicaid Trust Fund is hereby created in the State Treasury.

(b) Except as otherwise provided in this Section, any ~~Any~~ funds paid to the State by the federal government under Title XIX or Title XXI of the Social Security Act for services delivered by community mental health services providers, and any interest earned thereon, shall be deposited directly into the Community Mental Health Medicaid Trust Fund. Beginning with State fiscal year 2005, the first $95,000,000 received by the Department shall be deposited 26.3% into the General Revenue Fund and 73.7% into the Community Mental Health Medicaid Trust Fund. Amounts received in excess of $95,000,000 in any State fiscal year shall be deposited 50% into the General Revenue Fund and 50% into the Community Mental Health Medicaid Trust Fund. The Department shall analyze the budgeting and programmatic impact of this funding allocation and report to the Governor and the General Assembly the results of this analysis and any recommendations for change, no later than December 31, 2005.

(c) The Department shall reimburse community mental health services providers for Medicaid-reimbursed mental health services provided to eligible individuals. Moneys in the Community Mental Health Medicaid Trust Fund may be used for that purpose.

(d) As used in this Section:

"Medicaid-reimbursed mental health services" means services provided by a community mental health provider under an agreement with the Department that is eligible for

reimbursement under the federal Title XIX program or Title XXI program.

"Provider" means a community agency that is funded by the Department to provide a Medicaid-reimbursed service.

"Services" means mental health services provided under one of the following programs:

(1) Medicaid Clinic Option;

(2) Medicaid Rehabilitation Option;

(3) Targeted Case Management.

(Source: P.A. 92-597, eff. 6-28-02.)

(20 ILCS 1705/18.5 new)

Sec. 18.5. Community Developmental Disability Services Medicaid Trust Fund; reimbursement.

(a) The Community Developmental Disability Services Medicaid Trust Fund is hereby created in the State treasury.

(b) Any funds in excess of $16,700,000 in any fiscal year paid to the State by the federal government under Title XIX or Title XXI of the Social Security Act for services delivered by community developmental disability services providers for services relating to Developmental Training and Community Integrated Living Arrangements as a result of the conversion of such providers from a grant payment methodology to a fee-for-service payment methodology, or any other funds paid to the State for any subsequent revenue maximization initiatives performed by such providers, and any interest earned thereon, shall be deposited directly into the Community Developmental Disability Services Medicaid Trust Fund. One-third of this amount shall be used only to pay for Medicaid-reimbursed community developmental disability services provided to eligible individuals, and the remainder shall be transferred to the General Revenue Fund.

(c) For purposes of this Section:

"Medicaid-reimbursed developmental disability services" means services provided by a community developmental disability provider under an agreement with the Department that

is eligible for reimbursement under the federal Title XIX program or Title XXI program.

"Provider" means a qualified entity as defined in the State's Home and Community-Based Services Waiver for Persons with Developmental Disabilities that is funded by the Department to provide a Medicaid-reimbursed service.

"Revenue maximization alternatives" do not include increases in funds paid to the State as a result of growth in spending through service expansion or rate increases.

Section 20. The State Finance Act is amended by changing Sections 6z-58 and 25 and by adding Section 8.55 as follows:

(30 ILCS 105/6z-58)

Sec. 6z-58. The Family Care Fund.

(a) There is created in the State treasury the Family Care Fund. Interest earned by the Fund shall be credited to the Fund.

(b) The Fund is created ~~solely~~ for the purposes of receiving, investing, and distributing moneys in accordance with (i) an approved waiver under the Social Security Act resulting from the Family Care waiver request submitted by the Illinois Department of Public Aid on February 15, 2002 and (ii) an interagency agreement between the Department of Public Aid and another agency of State government. The Fund shall consist of:

(1) All federal financial participation moneys received pursuant to the approved waiver, except for moneys received pursuant to expenditures for medical services by the Department of Public Aid from any other fund; and

(2) All other moneys received by the Fund from any source, including interest thereon.

(c) Subject to appropriation, the moneys in the Fund shall be disbursed for reimbursement of medical services and other costs associated with persons receiving such services:

(1) under programs administered by the Department of

Public Aid; and

(2) pursuant to an interagency agreement, under programs administered by another agency of State government. ~~under the waiver due to their relationship with children receiving medical services pursuant to Article V of the Illinois Public Aid Code or the Children's Health Insurance Program Act.~~

(Source: P.A. 92-600, eff. 6-28-02; 93-20, eff. 6-20-03.)

(30 ILCS 105/8.55 new)

Sec. 8.55. Interfund transfers. On or after July 1, 2004 and until June 30, 2006, in addition to any other transfers that may be provided for by law, at the direction of and upon notification from the Director of Public Aid, the State Comptroller shall direct and the State Treasurer shall transfer amounts into the General Revenue Fund from the designated funds not exceeding the following totals:

Hospital Provider Fund $36,000,000

Health and Human Services Medicaid Trust Fund $124,000,000.

Transfers of moneys under this Section may not exceed a total of $80,000,000 in any State fiscal year.

(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.

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.

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.

Medical payments may be made by the Department of Public Aid and <u>medical payments and</u> 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 Central Management Services from the Health Insurance Reserve Fund and the Local Government Health Insurance Reserve Fund without regard to any fiscal year limitations.

<u>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</u>

the Department of Public Aid.

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.

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

Lease payments may be made by the Department of Central Management Services under the sale and leaseback provisions of Section 7.4 of the State Property Control Act with respect to the James R. Thompson Center and the Elgin Mental Health Center and surrounding land from appropriations for that purpose without regard to any fiscal year limitations.

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

(c) Further, payments may be made by the Department of Public Health and the Department of Human Services (acting as successor to the Department of Public Health under the Department of Human Services Act) from their respective appropriations for grants for medical care to or on behalf of 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.

(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 Public Aid, ~~and~~ 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 Public Aid 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 Public Aid's 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 based on estimated charges for goods or services;

(2) issuing credits during the subsequent fiscal year for all user agency payments 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 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.

(Source: P.A. 92-885, eff. 1-13-03; 93-19, eff. 6-20-03.)

Section 22. The Illinois Income Tax Act is amended by changing Section 917 as follows:

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

Sec. 917. Confidentiality and information sharing.

(a) Confidentiality. Except as provided in this Section, all information received by the Department from returns filed under this Act, or from any investigation conducted under the provisions of this Act, shall be confidential, except for official purposes within the Department or pursuant to official procedures for collection of any State tax or pursuant to an investigation or audit by the Illinois State Scholarship Commission of a delinquent student loan or monetary award or enforcement of any civil or criminal penalty or sanction imposed by this Act or by another statute imposing a State tax, and any person who divulges any such information in any manner, except for such purposes and pursuant to order of the Director or in accordance with a proper judicial order, shall be guilty of a Class A misdemeanor. However, the provisions of this paragraph are not applicable to information furnished to a licensed attorney representing the taxpayer where an appeal or a protest has been filed on behalf of the taxpayer.

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

(c) Governmental agencies. The Director may make available to the Secretary of the Treasury of the United States or his delegate, or the proper officer or his delegate of any other

state imposing a tax upon or measured by income, for exclusively official purposes, information received by the Department in the administration of this Act, but such permission shall be granted only if the United States or such other state, as the case may be, grants the Department substantially similar privileges. The Director may exchange information with the Illinois Department of Public Aid and the Department of Human Services (acting as successor to the Department of Public Aid under the Department of Human Services Act) for the purpose of verifying sources and amounts of income and for other purposes directly connected with the administration of this Act and the Illinois Public Aid Code. The Director may exchange information with the Director of the Department of Employment Security for the purpose of verifying sources and amounts of income and for other purposes directly connected with the administration of this Act and Acts administered by the Department of Employment Security. The Director may make available to the Illinois Industrial Commission information regarding employers for the purpose of verifying the insurance coverage required under the Workers' Compensation Act and Workers' Occupational Diseases Act. <u>The Director may exchange information with the Illinois Department on Aging for the purpose of verifying sources and amounts of income for purposes directly related to confirming eligibility for participation in the programs of benefits authorized by the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.</u>

The Director may make available to any State agency, including the Illinois Supreme Court, which licenses persons to engage in any occupation, information that a person licensed by such agency has failed to file returns under this Act or pay the tax, penalty and interest shown therein, or has failed to pay any final assessment of tax, penalty or interest due under this Act. The Director may make available to any State agency, including the Illinois Supreme Court, information regarding whether a bidder, contractor, or an affiliate of a bidder or

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

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

The Director may also make available to the Secretary of State information that a corporation which has been issued a certificate of incorporation by the Secretary of State has failed to file returns under this Act or pay the tax, penalty and interest shown therein, or has failed to pay any final assessment of tax, penalty or interest due under this Act. An assessment is final when all proceedings in court for review of such assessment have terminated or the time for the taking thereof has expired without such proceedings being instituted. For taxable years ending on or after December 31, 1987, the

Director may make available to the Director or principal officer of any Department of the State of Illinois, information that a person employed by such Department has failed to file returns under this Act or pay the tax, penalty and interest shown therein. For purposes of this paragraph, the word "Department" shall have the same meaning as provided in Section 3 of the State Employees Group Insurance Act of 1971.

(d) The Director shall make available for public inspection in the Department's principal office and for publication, at cost, administrative decisions issued on or after January 1, 1995. These decisions are to be made available in a manner so that the following taxpayer information is not disclosed:

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

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

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

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

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

(Source: P.A. 93-25, eff. 6-20-03.)

Section 25. The Nursing Home Care Act is amended by changing Section 3-103 as follows:

(210 ILCS 45/3-103) (from Ch. 111 1/2, par. 4153-103)

Sec. 3-103. The procedure for obtaining a valid license shall be as follows:

(1) Application to operate a facility shall be made to the Department on forms furnished by the Department.

(2) All license applications shall be accompanied with an application fee. The fee for an annual license shall be $995 ~~based on the licensed capacity of the facility and shall be determined as follows: 0-49 licensed beds, a flat fee of $500; 50-99 licensed beds, a flat fee of $750; and for any facility with 100 or more licensed beds, a fee of $1,000 plus $10 per licensed bed~~. Facilities that pay a fee or assessment pursuant to Article V-C of the Illinois Public Aid Code shall be exempt from the license fee imposed under this item (2). The fee for a 2-year license shall be double the fee for the annual license set forth in the preceding sentence. The ~~first $600,000 of such~~ fees collected ~~each fiscal year~~ shall be deposited with the State Treasurer into the Long Term Care Monitor/Receiver Fund, which has been created as a special fund in the State treasury. ~~Any such fees in excess of $600,000 collected in a fiscal year shall be deposited into the General Revenue Fund.~~ This special fund is to be used by the Department for expenses related to the appointment of monitors and receivers as contained in Sections 3-501 through 3-517. At the end of each fiscal year, any funds in excess of $1,000,000 held in the Long Term Care Monitor/Receiver Fund shall be deposited in the State's General Revenue Fund. The application shall be under oath and the submission of false or misleading information shall be a Class A misdemeanor. The application shall contain the following information:

(a) The name and address of the applicant if an

individual, and if a firm, partnership, or association, of every member thereof, and in the case of a corporation, the name and address thereof and of its officers and its registered agent, and in the case of a unit of local government, the name and address of its chief executive officer;

(b) The name and location of the facility for which a license is sought;

(c) The name of the person or persons under whose management or supervision the facility will be conducted;

(d) The number and type of residents for which maintenance, personal care, or nursing is to be provided; and

(e) Such information relating to the number, experience, and training of the employees of the facility, any management agreements for the operation of the facility, and of the moral character of the applicant and employees as the Department may deem necessary.

(3) Each initial application shall be accompanied by a financial statement setting forth the financial condition of the applicant and by a statement from the unit of local government having zoning jurisdiction over the facility's location stating that the location of the facility is not in violation of a zoning ordinance. An initial application for a new facility shall be accompanied by a permit as required by the "Illinois Health Facilities Planning Act". After the application is approved, the applicant shall advise the Department every 6 months of any changes in the information originally provided in the application.

(4) Other information necessary to determine the identity and qualifications of an applicant to operate a facility in accordance with this Act shall be included in the application as required by the Department in regulations.

(Source: P.A. 93-32, eff. 7-1-03.)

Section 27. The Pharmacy Practice Act of 1987 is amended by

changing Section 25 as follows:

(225 ILCS 85/25) (from Ch. 111, par. 4145)

(Section scheduled to be repealed on January 1, 2008)

Sec. 25. No person shall compound, or sell or offer for sale, or cause to be compounded, sold or offered for sale any medicine or preparation under or by a name recognized in the United States Pharmacopoeia National Formulary, for internal or external use, which differs from the standard of strength, quality or purity as determined by the test laid down in the United States Pharmacopoeia National Formulary official at the time of such compounding, sale or offering for sale. Nor shall any person compound, sell or offer for sale, or cause to be compounded, sold, or offered for sale, any drug, medicine, poison, chemical or pharmaceutical preparation, the strength or purity of which shall fall below the professed standard of strength or purity under which it is sold. If the physician or other authorized prescriber, when transmitting an oral or written prescription, does not prohibit drug product selection, a different brand name or nonbrand name drug product of the same generic name may be dispensed by the pharmacist, provided that the selected drug has a unit price less than the drug product specified in the prescription ~~and provided that the selection is permitted, is not subject to review at a meeting of the Technical Advisory Council, is not subject to a hearing in accordance with this Section, or is not specifically prohibited by the current Drug Product Selection Formulary issued by the Department of Public Health pursuant to Section 3.14 of the Illinois Food, Drug and Cosmetics Act, as amended~~. A generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration (FDA) shall be available for substitution in Illinois in accordance with this Act and the Illinois Food, Drug and Cosmetic Act, provided that each manufacturer submits <u>to the Director of the Department of Public Health</u> a notification containing product technical bioequivalence information as a prerequisite to product

substitution when they have completed all required testing to support FDA product approval and, in any event, the information shall be submitted no later than 60 days prior to product substitution in the State. ~~If the Technical Advisory Council finds that a generic drug product may have issues related to the practice of medicine or the practice of pharmacy, the Technical Advisory Council shall review the generic drug product at its next regularly scheduled Technical Advisory Council meeting. Following the Technical Advisory Council's review and initial recommendation that a generic drug product not be included in the Illinois Formulary, a hearing shall be conducted in accordance with the rules of the Department of Public Health and Article 10 of the Illinois Administrative Procedure Act if requested by the manufacturer. The Technical Advisory Council shall make its recommendation to the Department of Public Health within 20 business days after the public hearing. If the Department of Public Health, on the recommendation of the Technical Advisory Council, determines that, based upon a preponderance of the evidence, the drug is not bioequivalent, not therapeutically equivalent, or could cause clinically significant harm to the health or safety of patients receiving that generic drug, the Department of Public Health may prohibit the generic drug from substitution in the State. A decision by the Department of Public Health to prohibit a drug product from substitution shall constitute a final administrative decision within the meaning of Section 22.2 of the Illinois Food, Drug and Cosmetic Act and Section 3-101 of the Code of Civil Procedure, and shall be subject to judicial review pursuant to the provisions of Article III of the Administrative Review Law. A decision to prohibit a generic drug from substitution must be accompanied by a written detailed explanation of the basis for the decision.~~ On the prescription forms of prescribers, shall be placed a signature line and the words "may substitute" and "may not substitute". The prescriber, in his or her own handwriting, shall place a mark beside either the "may substitute" or "may not substitute"

alternatives to guide the pharmacist in the dispensing of the prescription. A prescriber placing a mark beside the "may substitute" alternative or failing in his or her own handwriting to place a mark beside either alternative authorizes drug product selection in accordance with this Act. Preprinted or rubber stamped marks, or other deviations from the above prescription format shall not be permitted. The prescriber shall sign the form in his or her own handwriting to authorize the issuance of the prescription. When a person presents a prescription to be dispensed, the pharmacist to whom it is presented may inform the person if the pharmacy has available a different brand name or nonbrand name of the same generic drug prescribed and the price of the different brand name or nonbrand name of the drug product. If the person presenting the prescription is the one to whom the drug is to be administered, the pharmacist may dispense the prescription with the brand prescribed or a different brand name or nonbrand name product of the same generic name ~~that has been permitted by the Department of Public Health~~, if the drug is of lesser unit cost and the patient is informed and agrees to the selection and the pharmacist shall enter such information into the pharmacy record. If the person presenting the prescription is someone other than the one to whom the drug is to be administered the pharmacist shall not dispense the prescription with a brand other than the one specified in the prescription unless the pharmacist has the written or oral authorization to select brands from the person to whom the drug is to be administered or a parent, legal guardian or spouse of that person.

In every case in which a selection is made as permitted by the Illinois Food, Drug and Cosmetic Act, the pharmacist shall indicate on the pharmacy record of the filled prescription the name or other identification of the manufacturer of the drug which has been dispensed.

The selection of any drug product by a pharmacist shall not constitute evidence of negligence if the selected nonlegend

drug product was of the same dosage form and each of its active ingredients did not vary by more than 1 percent from the active ingredients of the prescribed, brand name, nonlegend drug product ~~or if the selected legend drug product was included in the Illinois Drug Product Selection Formulary current at the time the prescription was dispensed~~. Failure of a prescribing physician to specify that drug product selection is prohibited does not constitute evidence of negligence unless that practitioner has reasonable cause to believe that the health condition of the patient for whom the physician is prescribing warrants the use of the brand name drug product and not another.

The Department is authorized to employ an analyst or chemist of recognized or approved standing whose duty it shall be to examine into any claimed adulteration, illegal substitution, improper selection, alteration, or other violation hereof, and report the result of his investigation, and if such report justify such action the Department shall cause the offender to be prosecuted.

(Source: P.A. 91-766, eff. 9-1-00; 92-112, eff. 7-20-01.)

Section 30. The Illinois Public Aid Code is amended by changing Sections 5-5, 5-5.4, 5A-2, 5A-4, 5A-5, 5A-7, and 5A-12 and adding Sections 5-5.4c and 12-10.7 as follows:

(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; (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; (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.

The Illinois Department of Public Aid 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, which shall include but not be limited to prosthodontics; and

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

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 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 baseline mammogram for women 35 to 39 years of age and an annual mammogram for women 40 years of age or older. 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. As used in 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, image

receptor, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

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 Public Aid 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 Illinois Department of Public Aid 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.

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. 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 conditional for 180 days. During that time, the Department of Public Aid may terminate the vendor's eligibility to participate in the medical assistance program without cause. That termination of eligibility is not subject to the Department's hearing process.

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. 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. ~~Rules under clause (2) above shall not provide for purchase or lease-purchase of durable medical equipment or supplies used for the purpose of oxygen delivery and respiratory care.~~

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.

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.

(Source: P.A. 92-16, eff. 6-28-01; 92-651, eff. 7-11-02;

92-789, eff. 8-6-02; 93-632, eff. 2-1-04.)

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

Sec. 5-5.4. Standards of Payment - Department of Public Aid. The Department of Public Aid shall develop standards of payment of skilled nursing and intermediate care services in facilities providing such services under this Article which:

(1) Provide for the determination of a facility's payment for skilled nursing and intermediate care services on a prospective basis. The amount of the payment rate for all nursing facilities certified by the Department of Public Health under 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 July 1, 2005 ~~2004~~, unless specifically provided for in this Section. The changes made by this amendatory Act of the 93rd General Assembly 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 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 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 of Public Aid 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 2 years 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.

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 Illinois Department shall determine by rule~~ the rates taking effect on July 1, 2004 ~~2003, which~~ shall be 3.0% greater ~~less~~ than the rates in effect on June 30, 2004 ~~2002~~. These rates ~~This rate~~ 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.

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.

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 Public Aid 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.
(Source: P.A. 92-10, eff. 6-11-01; 92-31, eff. 6-28-01; 92-597, eff. 6-28-02; 92-651, eff. 7-11-02; 92-848, eff. 1-1-03; 93-20, eff. 6-20-03; 93-649, eff. 1-8-04; 93-659, eff. 2-3-04; revised 2-3-04.)

(305 ILCS 5/5-5.4c new)

Sec. 5-5.4c. Bed reserves; approval. The Department of Public Aid shall approve bed reserves at a daily rate of 75% of an individual's current Medicaid per diem, for nursing facilities 90% or more of whose residents are Medicaid recipients and that have occupancy levels of at least 93% for resident bed reserves not exceeding 10 days.

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

(Section scheduled to be repealed on July 1, 2005)

Sec. 5A-2. Assessment; no local authorization to tax.

(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 for State fiscal years 2004 and 2005, if the payment methodologies required under 5A-12 and the waiver granted under 42 CFR 433.68 are approved with an effective date prior to July 1, 2004; or the assessment will be imposed for

fiscal year 2005 only, if the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68 are approved with an effective date on or after July 1, 2004 ~~in an amount equal to the hospital's occupied bed days multiplied by $84.19~~.

The Department of Public Aid 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 Public Aid, then the Department of Public Aid 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 Public Aid or its duly authorized agents and employees.

(b) Nothing in this amendatory Act of the 93rd General Assembly shall be construed to authorize any home rule unit or other unit of local government to license for revenue or to impose a tax or assessment upon hospital providers or the occupation of hospital provider, or a tax or assessment measured by the income or earnings of a hospital provider.

(c) As provided in Section 5A-14, this Section is repealed on July 1, 2005.

(Source: P.A. 93-659, eff. 2-3-04.)

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

Sec. 5A-4. Payment of assessment; penalty.

(a) 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. No

installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after: (i) the hospital provider receives written notice from the Department of Public Aid that the payment methodologies to hospitals required under Section 5A-12 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 has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the hospital has received the payments required under Section 5A-12. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68, all quarterly installments otherwise due under Section 5A-2 prior to the date of notification shall be due and payable to the Department within 30 days of the date of notification.

(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.

(Source: P.A. 93-659, eff. 2-3-04.)

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

Sec. 5A-5. Notice; penalty; maintenance of records.

(a) ~~After December 31 of each year (except as otherwise provided in this subsection), and on or before March 31 of the succeeding year, the~~ The Department of Public Aid 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 ~~for the State fiscal year commencing on the next July 1, except that the notice for the State fiscal year commencing July 1, 2003~~ shall be sent within 14 days of 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 Section 5A-12 and the waiver granted under 42 CFR 433.68 have been approved ~~on or before June 1, 2004~~. 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 of the hospital provider, 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 quarterly 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, 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.

(f) (Blank).

(g) (Blank).

(h) (Blank).

(Source: P.A. 93-659, eff. 2-3-04.)

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

Sec. 5A-7. Administration; enforcement provisions.

(a) The Illinois Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Illinois Department of Public Health, which shall show each provider's name and principal place of business

and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Illinois Department shall administer and enforce this Article and collect the assessments and penalty assessments imposed under this Article using procedures employed in its administration of this Code generally. The Illinois Department, its Director, and every hospital provider subject to assessment measured by occupied bed days shall have the following powers, duties, and rights:

(1) The Illinois Department may initiate either administrative or judicial proceedings, or both, to enforce provisions of this Article. Administrative enforcement proceedings initiated hereunder shall be governed by the Illinois Department's administrative rules. Judicial enforcement proceedings initiated hereunder shall be governed by the rules of procedure applicable in the courts of this State.

(2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than 3 years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Illinois Department and the hospital provider before the expiration of this limitation period.

(3) Any unpaid assessment under this Article shall become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of (A) the real property and improvements, (B) the machinery and equipment, or (C) the furniture or fixtures, of any hospital that is subject to the provisions of this Article, the seller or transferor shall pay the Illinois Department the amount of any assessment, assessment penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due,

the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Illinois Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Illinois Department showing that no assessment, penalty, or interest is due from the seller or transferor under this Article.

(4) Payments under this Article are not subject to the Illinois Prompt Payment Act. Credits or refunds shall not bear interest.

(b) In addition to any other remedy provided for and without sending a notice of assessment liability, the Illinois Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Illinois Department to the hospital provider.

~~(a) To the extent practicable, the Illinois Department shall administer and enforce this Article and collect the assessments, interest, and penalty assessments imposed under this Article using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA"). Instead of certificates of registration, the Illinois Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Department of Public Health, which shall show each provider's name, principal place of business,~~

~~and the name and address of each hospital operated, conducted, or maintained by the provider in this State. In addition, the following specified provisions of the Retailers' Occupation Tax Act are incorporated by reference into this Section except that the Illinois Department and its Director (rather than the Department of Revenue and its Director) and every hospital provider subject to assessment measured by occupied bed days (rather than persons subject to retailers' occupation tax measured by gross receipts from the sale of tangible personal property at retail) shall have the powers, duties, and rights specified in these ROTA provisions, as modified in this Section or by the Illinois Department in a manner consistent with this Article and except as manifestly inconsistent with the other provisions of this Article:~~

~~(1) ROTA, Section 4 (examination of return; notice of correction; evidence; limitations; protest and hearing), except that (i) the Illinois Department shall issue notices of assessment liability (rather than notices of tax liability as provided in ROTA, Section 4); (ii) in the case of a fraudulent return or in the case of an extended period agreed to by the Illinois Department and the hospital provider before the expiration of the limitation period, no notice of assessment liability shall be issued more than 3 years after the later of the due date of the return required by Section 5A-5 or the date the return (or an amended return) was filed (rather within the period stated in ROTA, Section 4); and (iii) the penalty provisions of ROTA, Section 4 shall not apply.~~

~~(2) ROTA, Sec. 5 (failure to make return; failure to pay assessment), except that the penalty and interest provisions of ROTA, Section 5 shall not apply.~~

~~(3) ROTA, Section 5a (lien; attachment; termination; notice; protest; review; release of lien; status of lien).~~

~~(4) ROTA, Section 5b (State lien notices; State lien index; duties of recorder and registrar of titles).~~

~~(5) ROTA, Section 5c (liens; certificate of release).~~

~~(6) ROTA, Section 5d (Department not required to furnish bond; claim to property attached or levied upon).~~

~~(7) ROTA, Section 5e (foreclosure on liens; enforcement).~~

~~(8) ROTA, Section 5f (demand for payment; levy and sale of property; limitation).~~

~~(9) ROTA, Section 5g (sale of property; redemption).~~

~~(10) ROTA, Section 5j (sales on transfers outside usual course of business; report; payment of assessment; rights and duties of purchaser; penalty), except that notice shall be provided to the Illinois Department as specified by rule.~~

~~(11) ROTA, Section 6 (erroneous payments; credit or refund), provided that (i) the Illinois Department may only apply an amount otherwise subject to credit or refund to a liability arising under this Article; (ii) except in the case of an extended period agreed to by the Illinois Department and the hospital provider before the expiration of this limitation period, a claim for credit or refund must be filed no more than 3 years after the due date of the return required by Section 5A-5 (rather than the time limitation stated in ROTA, Section 6); and (iii) credits or refunds shall not bear interest.~~

~~(12) ROTA, Section 6a (claims for credit or refund).~~

~~(13) ROTA, Section 6b (tentative determination of claim; notice; hearing; review), provided that a hospital provider or its representative shall have 60 days (rather than 20 days) within which to file a protest and request for hearing in response to a tentative determination of claim.~~

~~(14) ROTA, Section 6c (finality of tentative determinations).~~

~~(15) ROTA, Section 8 (investigations and hearings).~~

~~(16) ROTA, Section 9 (witness; immunity).~~

~~(17) ROTA, Section 10 (issuance of subpoenas; attendance of witnesses; production of books and records).~~

~~(18) ROTA, Section 11 (information confidential; exceptions).~~

~~(19) ROTA, Section 12 (rules and regulations; hearing; appeals), except that a hospital provider shall not be required to file a bond or be subject to a lien in lieu thereof in order to seek court review under the Administrative Review Law of a final assessment or revised final assessment or the equivalent thereof issued by the Illinois Department under this Article.~~

~~(b) In addition to any other remedy provided for and without sending a notice of assessment liability, the Illinois Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Illinois Department to the provider.~~

(Source: P.A. 93-659, eff. 2-3-04.)

(305 ILCS 5/5A-12)

(Section scheduled to be repealed on July 1, 2005)

Sec. 5A-12. Hospital access improvement payments.

(a) To improve access to hospital services, for hospital services rendered on or after June 1, 2004, the Department of Public Aid shall make payments to hospitals as set forth in this Section, except for hospitals described in subsection (b) of Section 5A-3. These payments shall be paid on a quarterly basis. For State fiscal year 2004, if the effective date of the approval of the payment methodology required under this Section and the waiver granted under 42 CFR 433.68 by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services is prior to July 1, 2004, the Department shall pay the total amounts required for fiscal year 2004 under this Section within 25 days of the latest notification~~; these amounts shall be paid on or before June 15 of the year~~. No payment shall be made for State fiscal year 2004 if the effective date of the approval is on or after July 1, 2004. In State fiscal year 2005 ~~subsequent State fiscal years~~, the total amounts required under this Section shall be paid in 4 equal

installments on or before July 15, October 15, January 14, and April 15 of the year, except that if the date of notification of the approval of the payment methodologies required under this Section and the waiver granted under 42 CFR 433.68 is on or after July 1, 2004, the sum of amounts required under this Section prior to the date of notification shall be paid within 25 days of the date of the last notification. 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, (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act, and (iii) the assessment is in effect.

(b) High volume payment. In addition to rates paid for inpatient hospital services, the Department of Public Aid shall pay, to each Illinois hospital that provided more than 20,000 Medicaid inpatient days of care during State fiscal year 2001 (except for hospitals that qualify for adjustment payments under Section 5-5.02 for the 12-month period beginning on October 1, 2002), $190 for each Medicaid inpatient day of care provided during that fiscal year. A hospital that provided less than 30,000 Medicaid inpatient days of care during that period, however, is not entitled to receive more than $3,500,000 per year in such payments.

(c) Medicaid inpatient utilization rate adjustment. In addition to rates paid for inpatient hospital services, the Department of Public Aid shall pay each Illinois hospital (except for hospitals described in Section 5A-3), for each Medicaid inpatient day of care provided during State fiscal year 2001, an amount equal to the product of $57.25 multiplied by the quotient of 1 divided by the greater of 1.6% or the hospital's Medicaid inpatient utilization rate (as used to determine eligibility for adjustment payments under Section 5-5.02 for the 12-month period beginning on October 1, 2002). The total payments under this subsection to a hospital may not exceed $10,500,000 annually.

(d) Psychiatric base rate adjustment.

(1) In addition to rates paid for inpatient psychiatric services, the Department of Public Aid shall pay each Illinois general acute care hospital with a distinct part-psychiatric unit, for each Medicaid inpatient psychiatric day of care provided in State fiscal year 2001, an amount equal to $400 less the hospital's per-diem rate for Medicaid inpatient psychiatric services as in effect on October 1, 2003. In no event, however, shall that amount be less than zero.

(2) For distinct part-psychiatric units of Illinois general acute care hospitals, except for all hospitals excluded in Section 5A-3, whose inpatient per-diem rate as in effect on October 1, 2003 is greater than $400, the Department shall pay, in addition to any other amounts authorized under this Code, $25 for each Medicaid inpatient psychiatric day of care provided in State fiscal year 2001.

(e) Supplemental tertiary care adjustment. In addition to rates paid for inpatient services, the Department of Public Aid 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 2003, 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 2003.

(f) Medicaid outpatient utilization rate adjustment. In addition to rates paid for outpatient hospital services, the Department of Public Aid shall pay each Illinois hospital (except for hospitals described in Section 5A-3), an amount equal to the product of 2.45% multiplied by the hospital's Medicaid outpatient charges multiplied by the quotient of 1 divided by the greater of 1.6% or the hospital's Medicaid outpatient utilization rate. The total payments under this subsection to a hospital may not exceed $6,750,000 annually.

For purposes of this subsection:

"Medicaid outpatient charges" means the charges for

outpatient services provided to Medicaid patients for State fiscal year 2001 as submitted by the hospital on the UB-92 billing form or under the ambulatory procedure listing and adjudicated by the Department of Public Aid on or before September 12, 2003.

"Medicaid outpatient utilization rate" means a fraction, the numerator of which is the hospital's Medicaid outpatient charges and the denominator of which is the total number of the hospital's charges for outpatient services for the hospital's fiscal year ending in 2001.

(g) State outpatient service adjustment. In addition to rates paid for outpatient hospital services, the Department of Public Aid shall pay each Illinois hospital an amount equal to the product of 75.5% multiplied by the hospital's Medicaid outpatient services submitted to the Department on the UB-92 billing form for State fiscal year 2001 multiplied by the hospital's outpatient access fraction.

For purposes of this subsection, "outpatient access fraction" means a fraction, the numerator of which is the hospital's Medicaid payments for outpatient services for ambulatory procedure listing services submitted to the Department on the UB-92 billing form for State fiscal year 2001, and the denominator of which is the hospital's Medicaid outpatient services submitted to the Department on the UB-92 billing form for State fiscal year 2001.

The total payments under this subsection to a hospital may not exceed $3,000,000 annually.

(h) Rural hospital outpatient adjustment. In addition to rates paid for outpatient hospital services, the Department of Public Aid shall pay each Illinois rural hospital an amount equal to the product of $14,500,000 multiplied by the rural hospital outpatient adjustment fraction.

For purposes of this subsection, "rural hospital outpatient adjustment fraction" means a fraction, the numerator of which is the hospital's Medicaid visits for outpatient services for ambulatory procedure listing services

submitted to the Department on the UB-92 billing form for State fiscal year 2001, and the denominator of which is the total Medicaid visits for outpatient services for ambulatory procedure listing services for all Illinois rural hospitals submitted to the Department on the UB-92 billing form for State fiscal year 2001.

For purposes of this subsection, "rural hospital" has the same meaning as in 89 Ill. Adm. Code 148.25, as in effect on September 30, 2003.

(i) Merged/closed hospital adjustment. If any hospital files a combined Medicaid cost report with another hospital after January 1, 2001, and if that hospital subsequently closes, then except for the payments described in subsection (e), all payments described in the various subsections of this Section shall, before the application of the annual limitation amount specified in each such subsection, be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the number of occupied bed days of each open hospital and each closed hospital. For purposes of this subsection, "occupied bed days" has the same meaning as the term is defined in subsection (a) of Section 5A-2.

(j) For purposes of this Section, the terms "Medicaid days", "Medicaid charges", and "Medicaid services" do not include any days, charges, or services for which Medicare was liable for payment.

(k) As provided in Section 5A-14, this Section is repealed on July 1, 2005.

(Source: P.A. 93-659, eff. 2-3-04.)

(305 ILCS 5/12-10.7 new)

Sec. 12-10.7. The Health and Human Services Medicaid Trust Fund.

(a) The Health and Human Services Medicaid Trust Fund shall consist of (i) moneys appropriated or transferred into the Fund, pursuant to statute, (ii) federal financial

participation moneys received pursuant to expenditures from the Fund, and (iii) the interest earned on moneys in the Fund.

(b) Subject to appropriation, the moneys in the Fund shall be used by a State agency for such purposes as that agency may, by the appropriation language, be directed.

Section 35. The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is amended by changing Section 6 as follows:

(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) Pharmaceutical Assistance. The Department shall allow all pharmacies licensed under the Pharmacy Practice Act of 1987 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;

(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.

(Source: P.A. 91-357, eff. 7-29-99; 92-651, eff. 7-11-02.)

Section 40. The Illinois Food, Drug and Cosmetic Act is amended by changing Section 3.14 as follows:

(410 ILCS 620/3.14) (from Ch. 56 1/2, par. 503.14)

Sec. 3.14. Dispensing or causing to be dispensed a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing. However, this Section does not prohibit the interchange of different brands of the same

generically equivalent drug product, when the drug products are not required to bear the legend "Caution: Federal law prohibits dispensing without prescription", provided that the same dosage form is dispensed and there is no greater than 1% variance in the stated amount of each active ingredient of the drug products. ~~Nothing in this Section shall prohibit the selection of different brands of the same generic drug, based upon a drug formulary listing which is developed, maintained, and issued by the Department of Public Health under which drug product selection is permitted, is not subject to review at a meeting of the Technical Advisory Council, is not subject to a hearing in accordance with this Section, or is not specifically prohibited.~~ A generic drug determined to be therapeutically equivalent by the United States Food and Drug Administration (FDA) shall be available for substitution in Illinois in accordance with this Act and the Pharmacy Practice Act of 1987, provided that each manufacturer submits to the Director of the Department of Public Health a notification containing product technical bioequivalence information as a prerequisite to product substitution when they have completed all required testing to support FDA product approval and, in any event, the information shall be submitted no later than 60 days prior to product substitution in the State. ~~If the Technical Advisory Council finds that a generic drug product may have issues related to the practice of medicine or the practice of pharmacy, the Technical Advisory Council shall review the generic drug product at its next regularly scheduled Technical Advisory Council meeting. Following the Technical Advisory Council's review and initial recommendation that a generic drug product not be included in the Illinois Formulary, a hearing shall be conducted in accordance with the Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Admin. Code 100) and Article 10 of the Illinois Administrative Procedure Act if requested by the manufacturer. The Technical Advisory Council shall make its recommendation to the Department of Public Health within 20 business days after the~~

~~public hearing. If the Department of Public Health, on the recommendation of the Technical Advisory Council, determines that, based upon a preponderance of the evidence, the drug is not bioequivalent, not therapeutically equivalent, or could cause clinically significant harm to the health or safety of patients receiving that generic drug, the Department of Public Health may prohibit the generic drug from substitution in the State. A decision by the Department to prohibit a drug product from substitution shall constitute a final administrative decision within the meaning of Section 22.2 of the Illinois Food, Drug and Cosmetic Act and Section 3-101 of the Code of Civil Procedure, and shall be subject to judicial review pursuant to the provisions of Article III of the Administrative Review Law. A decision to prohibit a generic drug from substitution must be accompanied by a written detailed explanation of the basis for the decision. Determination of products which may be selected shall be recommended by a Technical Advisory Council of the Department, selected by the Director of Public Health, which council shall consist of 7 persons including 2 physicians, 2 pharmacists, 2 pharmacologists and one other prescriber who have special knowledge of generic drugs and formulary. Technical Advisory Council members shall serve without pay, and shall be appointed for a 3 year term and until their successors are appointed and qualified. The procedures for operation of the Drug Product Selection Program shall be promulgated by the Director, however the actual list of products prohibited or approved for drug product selection need not be promulgated. The Technical Advisory Council shall take cognizance of federal studies, the U.S. Pharmacopoeia - National Formulary, or other recognized authoritative sources, and shall advise the Director of any necessary modifications. Drug products previously approved by the Technical Advisory Council for generic interchange may be substituted in the State of Illinois without further review subject to the conditions of approval in the State of Illinois prior to the effective date of this amendatory Act of the 91st~~

~~General Assembly.~~

~~Timely notice of revisions to the formulary shall be furnished at no charge to all pharmacies by the Department. Single copies of the drug formulary shall be made available at no charge upon request to licensed prescribers, student pharmacists, and pharmacists practicing pharmacy in this State under a reciprocal license. The Department shall offer subscriptions to the drug formulary and its revisions to other interested parties at a reasonable charge to be established by rule. Before the Department makes effective any additions to or deletions from the procedures for operation of the Drug Product Selection Program under this Section, the Department shall file proposed rules to amend the procedures for operation of the program under Section 5-40 of the Illinois Administrative Procedure Act. The Department shall issue necessary rules and regulations for the implementation of this Section.~~

(Source: P.A. 91-766, eff. 9-1-00; 92-112, eff. 7-20-01.)

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