Sen. Donne E. Trotter

Filed: 8/14/2007

AMENDMENT TO HOUSE BILL 691

AMENDMENT NO. _____. Amend House Bill 691, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the FY08 Human Services Budget Implementation Act.

Section 3. The State Employees Group Insurance Act of 1971 is amended by changing Section 10 as follows:

(5 ILCS 375/10) (from Ch. 127, par. 530)

Sec. 10. Payments by State; premiums.

(a) The State shall pay the cost of basic non-contributory group life insurance and, subject to member paid contributions set by the Department or required by this Section, the basic program of group health benefits on each eligible member, except a member, not otherwise covered by this Act, who has

retired as a participating member under Article 2 of the Illinois Pension Code but is ineligible for the retirement annuity under Section 2-119 of the Illinois Pension Code, and part of each eligible member's and retired member's premiums for health insurance coverage for enrolled dependents as provided by Section 9. The State shall pay the cost of the basic program of group health benefits only after benefits are reduced by the amount of benefits covered by Medicare for all members and dependents who are eligible for benefits under Social Security or the Railroad Retirement system or who had sufficient Medicare-covered government employment, except that such reduction in benefits shall apply only to those members and dependents who (1) first become eligible for such Medicare coverage on or after July 1, 1992; or (2) are Medicare-eligible members or dependents of a local government unit which began participation in the program on or after July 1, 1992; or (3) remain eligible for, but no longer receive Medicare coverage which they had been receiving on or after July 1, 1992. The Department may determine the aggregate level of the State's contribution on the basis of actual cost of medical services adjusted for age, sex or geographic or other demographic characteristics which affect the costs of such programs.

The cost of participation in the basic program of group health benefits for the dependent or survivor of a living or deceased retired employee who was formerly employed by the University of Illinois in the Cooperative Extension Service and

would be an annuitant but for the fact that he or she was made ineligible to participate in the State Universities Retirement System by clause (4) of subsection (a) of Section 15-107 of the Illinois Pension Code shall not be greater than the cost of participation that would otherwise apply to that dependent or survivor if he or she were the dependent or survivor of an annuitant under the State Universities Retirement System.

(a-1) Beginning January 1, 1998, for each person who becomes a new SERS annuitant and participates in the basic program of group health benefits, the State shall contribute toward the cost of the annuitant's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of creditable service upon which the annuitant's retirement annuity is based, up to a maximum of 100% for an annuitant with 20 or more years of creditable service. The remainder of the cost of a new SERS annuitant's coverage under the basic program of group health benefits shall be the responsibility of the annuitant. In the case of a new SERS annuitant who has elected to receive an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code in lieu of an annuity, for the purposes of this subsection the annuitant shall be deemed to be receiving a retirement annuity based on the number of years of creditable service that the annuitant had established at the time of his or her termination of service under SERS.

(a-2) Beginning January 1, 1998, for each person who

becomes a new SERS survivor and participates in the basic program of group health benefits, the State shall contribute toward the cost of the survivor's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of the deceased employee's or deceased annuitant's creditable service in the State Employees' Retirement System of Illinois on the date of death, up to a maximum of 100% for a survivor of an employee or annuitant with 20 or more years of creditable service. The remainder of the cost of the new SERS survivor's coverage under the basic program of group health benefits shall be the responsibility of the survivor. In the case of a new SERS survivor who was the dependent of an annuitant who elected to receive an alternative retirement cancellation payment under Section 14-108.5 of the Illinois Pension Code in lieu of an annuity, for the purposes of this subsection the deceased annuitant's creditable service shall be determined as of the date of termination of service rather than the date of death.

(a-3) Beginning January 1, 1998, for each person who becomes a new SURS annuitant and participates in the basic program of group health benefits, the State shall contribute toward the cost of the annuitant's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of creditable service upon which the annuitant's retirement annuity is based, up to a maximum of 100% for an annuitant with 20 or more years of creditable

service. The remainder of the cost of a new SURS annuitant's coverage under the basic program of group health benefits shall be the responsibility of the annuitant.

(a-4) (Blank).

(a-5) Beginning January 1, 1998, for each person who becomes a new SURS survivor and participates in the basic program of group health benefits, the State shall contribute toward the cost of the survivor's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of the deceased employee's or deceased annuitant's creditable service in the State Universities Retirement System on the date of death, up to a maximum of 100% for a survivor of an employee or annuitant with 20 or more years of creditable service. The remainder of the cost of the new SURS survivor's coverage under the basic program of group health benefits shall be the responsibility of the survivor.

(a-6) Beginning July 1, 1998, for each person who becomes a new TRS State annuitant and participates in the basic program of group health benefits, the State shall contribute toward the cost of the annuitant's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of creditable service as a teacher as defined in paragraph (2), (3), or (5) of Section 16-106 of the Illinois Pension Code upon which the annuitant's retirement annuity is based, up to a maximum of 100%; except that the State contribution shall be 12.5% per year (rather than 5%) for each

full year of creditable service as a regional superintendent or assistant regional superintendent of schools. The remainder of the cost of a new TRS State annuitant's coverage under the basic program of group health benefits shall be the responsibility of the annuitant.

(a-7) Beginning July 1, 1998, for each person who becomes a new TRS State survivor and participates in the basic program of group health benefits, the State shall contribute toward the cost of the survivor's coverage under the basic program of group health benefits an amount equal to 5% of that cost for each full year of the deceased employee's or deceased annuitant's creditable service as a teacher as defined in paragraph (2), (3), or (5) of Section 16-106 of the Illinois Pension Code on the date of death, up to a maximum of 100%; except that the State contribution shall be 12.5% per year (rather than 5%) for each full year of the deceased employee's or deceased annuitant's creditable service as a regional superintendent or assistant regional superintendent of schools. The remainder of the cost of the new TRS State survivor's coverage under the basic program of group health benefits shall be the responsibility of the survivor.

(a-8) A new SERS annuitant, new SERS survivor, new SURS annuitant, new SURS survivor, new TRS State annuitant, or new TRS State survivor may waive or terminate coverage in the program of group health benefits. Any such annuitant or survivor who has waived or terminated coverage may enroll or

re-enroll in the program of group health benefits only during the annual benefit choice period, as determined by the Director; except that in the event of termination of coverage due to nonpayment of premiums, the annuitant or survivor may not re-enroll in the program.

(a-9) No later than May 1 of each calendar year, the Director of Central Management Services shall certify in writing to the Executive Secretary of the State Employees' Retirement System of Illinois the amounts of the Medicare supplement health care premiums and the amounts of the health care premiums for all other retirees who are not Medicare eligible.

A separate calculation of the premiums based upon the actual cost of each health care plan shall be so certified.

The Director of Central Management Services shall provide to the Executive Secretary of the State Employees' Retirement System of Illinois such information, statistics, and other data as he or she may require to review the premium amounts certified by the Director of Central Management Services.

(b) State employees who become eligible for this program on or after January 1, 1980 in positions normally requiring actual performance of duty not less than 1/2 of a normal work period but not equal to that of a normal work period, shall be given the option of participating in the available program. If the employee elects coverage, the State shall contribute on behalf of such employee to the cost of the employee's benefit and any

applicable dependent supplement, that sum which bears the same percentage as that percentage of time the employee regularly works when compared to normal work period.

(c) The basic non-contributory coverage from the basic program of group health benefits shall be continued for each employee not in pay status or on active service by reason of (1) leave of absence due to illness or injury, (2) authorized educational leave of absence or sabbatical leave, or (3) military leave with pay and benefits. This coverage shall continue until expiration of authorized leave and return to active service, but not to exceed 24 months for leaves under item (1) or (2). This 24-month limitation and the requirement of returning to active service shall not apply to persons receiving ordinary or accidental disability benefits or retirement benefits through the appropriate State retirement system or benefits under the Workers' Compensation or Occupational Disease Act.

(d) The basic group life insurance coverage shall continue, with full State contribution, where such person is (1) absent from active service by reason of disability arising from any cause other than self-inflicted, (2) on authorized educational leave of absence or sabbatical leave, or (3) on military leave with pay and benefits.

(e) Where the person is in non-pay status for a period in excess of 30 days or on leave of absence, other than by reason of disability, educational or sabbatical leave, or military

leave with pay and benefits, such person may continue coverage only by making personal payment equal to the amount normally contributed by the State on such person's behalf. Such payments and coverage may be continued: (1) until such time as the person returns to a status eligible for coverage at State expense, but not to exceed 24 months, (2) until such person's employment or annuitant status with the State is terminated, or (3) for a maximum period of 4 years for members on military leave with pay and benefits and military leave without pay and benefits (exclusive of any additional service imposed pursuant to law).

(f) The Department shall establish by rule the extent to which other employee benefits will continue for persons in non-pay status or who are not in active service.

(g) The State shall not pay the cost of the basic non-contributory group life insurance, program of health benefits and other employee benefits for members who are survivors as defined by paragraphs (1) and (2) of subsection (q) of Section 3 of this Act. The costs of benefits for these survivors shall be paid by the survivors or by the University of Illinois Cooperative Extension Service, or any combination thereof. However, the State shall pay the amount of the reduction in the cost of participation, if any, resulting from the amendment to subsection (a) made by this amendatory Act of the 91st General Assembly.

(h) Those persons occupying positions with any department

as a result of emergency appointments pursuant to Section 8b.8 of the Personnel Code who are not considered employees under this Act shall be given the option of participating in the programs of group life insurance, health benefits and other employee benefits. Such persons electing coverage may participate only by making payment equal to the amount normally contributed by the State for similarly situated employees. Such amounts shall be determined by the Director. Such payments and coverage may be continued until such time as the person becomes an employee pursuant to this Act or such person's appointment is terminated.

(i) Any unit of local government within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a unit of local government must agree to enroll all of its employees, who may select coverage under either the State group health benefits plan or a health maintenance organization that has contracted with the State to be available as a health care provider for employees as defined in this Act. A unit of local government must remit the entire cost of providing coverage under the State group health benefits plan or, for coverage under a health maintenance organization, an amount determined by the Director based on an analysis of the sex, age, geographic location, or other relevant demographic variables for its employees, except that the unit of local government

shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the unit of local government attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 85% of the employees are enrolled and the unit of local government remits the entire cost of providing coverage to those employees, except that a participating school district must have enrolled at least 85% of its full-time employees who have not waived coverage under the district's group health plan by participating in a component of the district's cafeteria plan. A participating school district is not required to enroll a full-time employee who has waived coverage under the district's health plan, provided that an appropriate official from the participating school district attests that the full-time employee has waived coverage by participating in a component of the district's cafeteria plan. For the purposes of this subsection, "participating school district" includes a unit of local government whose primary purpose is education as defined by the Department's rules.

Employees of a participating unit of local government who are not enrolled due to coverage under another group health policy or plan may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A

participating unit of local government may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the unit of local government, its employees, or some combination of the two as determined by the unit of local government. The unit of local government shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine monthly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages, or contributed by the State for basic insurance coverages on behalf of its employees, adjusted for differences between State employees and employees of the local government in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the unit of local government and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the unit of local government.

In the case of coverage of local government employees under a health maintenance organization, the Director shall annually

determine for each participating unit of local government the maximum monthly amount the unit may contribute toward that coverage, based on an analysis of (i) the age, sex, geographic location, and other relevant demographic variables of the unit's employees and (ii) the cost to cover those employees under the State group health benefits plan. The Director may similarly determine the maximum monthly amount each unit of local government may contribute toward coverage of its employees' dependents under a health maintenance organization.

Monthly payments by the unit of local government or its employees for group health benefits plan or health maintenance organization coverage shall be deposited in the Local Government Health Insurance Reserve Fund.

The Local Government Health Insurance Reserve Fund is hereby created as a nonappropriated trust fund to be held outside the State Treasury, with the State Treasurer as custodian. The Local Government Health Insurance Reserve Fund shall be a continuing fund not subject to fiscal year limitations. All revenues arising from the administration of the health benefits program established under this Section shall be deposited into the Local Government Health Insurance Reserve Fund. Any interest earned on moneys in the Local Government Health Insurance Reserve Fund shall be deposited into the Fund. All expenditures from this Fund shall be used for payments for health care benefits for local government and rehabilitation facility employees, annuitants, and dependents,

and to reimburse the Department or its administrative service organization for all expenses incurred in the administration of benefits. No other State funds may be used for these purposes.

A local government employer's participation or desire to participate in a program created under this subsection shall not limit that employer's duty to bargain with the representative of any collective bargaining unit of its employees.

(j) Any rehabilitation facility within the State of Illinois may apply to the Director to have its employees, annuitants, and their eligible dependents provided group health coverage under this Act on a non-insured basis. To participate, a rehabilitation facility must agree to enroll all of its employees and remit the entire cost of providing such coverage for its employees, except that the rehabilitation facility shall not be required to enroll those of its employees who are covered spouses or dependents under this plan or another group policy or plan providing health benefits as long as (1) an appropriate official from the rehabilitation facility attests that each employee not enrolled is a covered spouse or dependent under this plan or another group policy or plan, and (2) at least 85% of the employees are enrolled and the rehabilitation facility remits the entire cost of providing coverage to those employees. Employees of a participating rehabilitation facility who are not enrolled due to coverage under another group health policy or plan may enroll in the

event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period. A participating rehabilitation facility may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the rehabilitation facility, its employees, or some combination of the 2 as determined by the rehabilitation facility. The rehabilitation facility shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine quarterly rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the rehabilitation facility in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the rehabilitation facility and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the rehabilitation facility.

Monthly payments by the rehabilitation facility or its

employees for group health benefits shall be deposited in the Local Government Health Insurance Reserve Fund.

(k) Any domestic violence shelter or service within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependents provided group health coverage under this Act on a non-insured basis. To participate, a domestic violence shelter or service must agree to enroll all of its employees and pay the entire cost of providing such coverage for its employees. A participating domestic violence shelter may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with employees, or some combination of the 2 as determined by the domestic violence shelter or service. The domestic violence shelter or service shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its employees, adjusted for differences between State employees and employees of the domestic violence shelter or service in age, sex, geographic location or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage

to employees of the domestic violence shelter or service and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the domestic violence shelter or service.

Monthly payments by the domestic violence shelter or service or its employees for group health insurance shall be deposited in the Local Government Health Insurance Reserve Fund.

(l) A public community college or entity organized pursuant to the Public Community College Act may apply to the Director initially to have only annuitants not covered prior to July 1, 1992 by the district's health plan provided health coverage under this Act on a non-insured basis. The community college must execute a 2-year contract to participate in the Local Government Health Plan. Any annuitant may enroll in the event of a qualifying change in status, special enrollment, special circumstance as defined by the Director, or during the annual Benefit Choice Period.

The Director shall annually determine monthly rates of payment subject to the following constraints: for those community colleges with annuitants only enrolled, first year rates shall be equal to the average cost to cover claims for a State member adjusted for demographics, Medicare participation, and other factors; and in the second year, a

further adjustment of rates shall be made to reflect the actual first year's claims experience of the covered annuitants.

(l-5) The provisions of subsection (l) become inoperative on July 1, 1999.

(m) The Director shall adopt any rules deemed necessary for implementation of this amendatory Act of 1989 (Public Act 86-978).

(n) Any child advocacy center within the State of Illinois may apply to the Director to have its employees, annuitants, and their dependants provided group health coverage under this Act on a non-insured basis. To participate, a child advocacy center must agree to enroll all of its employees and pay the entire cost of providing coverage for its employees. A participating child advocacy center may also elect to cover its annuitants. Dependent coverage shall be offered on an optional basis, with the costs paid by the child advocacy center, its employees, or some combination of the 2 as determined by the child advocacy center. The child advocacy center shall be responsible for timely collection and transmission of dependent premiums.

The Director shall annually determine rates of payment, subject to the following constraints:

(1) In the first year of coverage, the rates shall be equal to the amount normally charged to State employees for elected optional coverages or for enrolled dependents coverages or other contributory coverages on behalf of its

employees, adjusted for differences between State employees and employees of the child advocacy center in age, sex, geographic location, or other relevant demographic variables, plus an amount sufficient to pay for the additional administrative costs of providing coverage to employees of the child advocacy center and their dependents.

(2) In subsequent years, a further adjustment shall be made to reflect the actual prior years' claims experience of the employees of the child advocacy center.

Monthly payments by the child advocacy center or its employees for group health insurance shall be deposited into the Local Government Health Insurance Reserve Fund.

(Source: P.A. 93-839, eff. 7-30-04; 94-839, eff. 6-6-06; 94-860, eff. 6-16-06; revised 8-3-06.)

Section 5. The Mental Health and Developmental Disabilities Administrative Act is amended by changing Section 18.5 as follows:

(20 ILCS 1705/18.5)

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) Except as provided in subsection (b-5), any ~~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.

(b-5) Beginning in State fiscal year 2008, any funds paid to the State by the federal government under Title XIX or Title XXI of the Social Security Act for services delivered through the Children's Residential Waiver and the Children's In-Home Support Waiver shall be deposited directly into the Community Developmental Disability Services Medicaid Trust Fund and shall not be subject to the transfer provisions of subsection (b).

(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.

(Source: P.A. 93-841, eff. 7-30-04.)

Section 7. The State Finance Act is amended by adding Sections 5.675 and 6z-69 and changing Section 8.27 as follows:

(30 ILCS 105/5.675 new)

Sec. 5.675. The Priority Capital Grant Program Fund.

(30 ILCS 105/6z-69 new)

Sec. 6z-69. Priority Capital Grant Program Fund. The Priority Capital Grant Program Fund is created as a special fund in the State treasury. Subject to appropriation, the Department of Human Services shall use moneys in the Fund to make grants to the Illinois Facilities Fund, a not-for-profit corporation, to make long term below market rate loans and

grants to assist nonprofit human service providers working under contract to the State of Illinois to assist those providers in meeting their capital needs. The loans or grants shall be for the purpose of such capital needs, including but not limited to special use facilities, requirements for serving the disabled, mentally ill, or substance abusers, and medical and technology equipment. Loan repayments shall be deposited into the Priority Capital Grant Program Fund. Interest income may be used to cover expenses of the program.

(30 ILCS 105/8.27) (from Ch. 127, par. 144.27)

Sec. 8.27. All receipts from federal financial participation in the Foster Care and Adoption Services program under Title IV-E of the federal Social Security Act, including receipts for related indirect costs, shall be deposited in the DCFS Children's Services Fund.

Eighty percent of the federal funds received by the Illinois Department of Human Services under the Title IV-A Emergency Assistance program as reimbursement for expenditures made from the Illinois Department of Children and Family Services appropriations for the costs of services in behalf of Department of Children and Family Services clients shall be deposited into the DCFS Children's Services Fund.

All receipts from federal financial participation in the Child Welfare Services program under Title IV-B of the federal Social Security Act, including receipts for related indirect

costs, shall be deposited into the DCFS Children's Services Fund for those moneys received as reimbursement for services provided on or after July 1, 1994.

In addition, as soon as may be practicable after the first day of November, 1994, the Department of Children and Family Services shall request the Comptroller to order transferred and the Treasurer shall transfer the unexpended balance of the Child Welfare Services Fund to the DCFS Children's Services Fund. Upon completion of the transfer, the Child Welfare Services Fund will be considered dissolved and any outstanding obligations or liabilities of that fund will pass to the DCFS Children's Services Fund.

For services provided on or after July 1, 2007, all federal funds received pursuant to the John H. Chafee Foster Care Independence Program shall be deposited into the DCFS Children's Services Fund.

Monies in the Fund may be used by the Department, pursuant to appropriation by the General Assembly, for the ordinary and contingent expenses of the Department.

In fiscal year 1988 and in each fiscal year thereafter through fiscal year 2000, the Comptroller shall order transferred and the Treasurer shall transfer an amount of $16,100,000 from the DCFS Children's Services Fund to the General Revenue Fund in the following manner: As soon as may be practicable after the 15th day of September, December, March and June, the Comptroller shall order transferred and the

Treasurer shall transfer, to the extent that funds are available, 1/4 of $16,100,000, plus any cumulative deficiencies in such transfers for prior transfer dates during such fiscal year. In no event shall any such transfer reduce the available balance in the DCFS Children's Services Fund below $350,000.

In accordance with subsection (q) of Section 5 of the Children and Family Services Act, disbursements from individual children's accounts shall be deposited into the DCFS Children's Services Fund.

Receipts from public and unsolicited private grants, fees for training, and royalties earned from the publication of materials owned by or licensed to the Department of Children and Family Services shall be deposited into the DCFS Children's Services Fund.

As soon as may be practical after September 1, 2005, upon the request of the Department of Children and Family Services, the Comptroller shall order transferred and the Treasurer shall transfer the unexpended balance of the Department of Children and Family Services Training Fund into the DCFS Children's Services Fund. Upon completion of the transfer, the Department of Children and Family Services Training Fund is dissolved and any outstanding obligations or liabilities of that Fund pass to the DCFS Children's Services Fund.

(Source: P.A. 94-91, eff. 7-1-05.)

Section 9. The Hospital Licensing Act is amended by changing Section 8 as follows:

(210 ILCS 85/8) (from Ch. 111 1/2, par. 149)

Sec. 8. Facility plan review; fees.

(a) Before commencing construction of new facilities or specified types of alteration or additions to an existing hospital involving major construction, as defined by rule by the Department, with an estimated cost greater than $100,000, architectural plans and specifications therefor shall be submitted by the licensee to the Department for review and approval. A hospital may submit architectural drawings and specifications for other construction projects for Department review according to subsection (b) that shall not be subject to fees under subsection (d). The Department must give a hospital that is planning to submit a construction project for review the opportunity to discuss its plans and specifications with the Department before the hospital formally submits the plans and specifications for Department review. Review of drawings and specifications shall be conducted by an employee of the Department meeting the qualifications established by the Department of Central Management Services class specifications for such an individual's position or by a person contracting with the Department who meets those class specifications. Final approval of the plans and specifications for compliance with design and construction standards shall be obtained from the

Department before the alteration, addition, or new construction is begun. Subject to this Section 8, and prior to January 1, 2012, the Department shall consider the re-licensing of an existing hospital structure according to the standards for an existing hospital, as set forth in the Department's rules. Re-licensing under this provision shall occur only if that facility operated as a licensed hospital on July 1, 2005, has had no intervening use as other than a hospital, and exists in a county with a population of less than 20,000 that does not have another licensed hospital on the effective date of this amendatory Act of the 95th General Assembly.

(b) The Department shall inform an applicant in writing within 10 working days after receiving drawings and specifications and the required fee, if any, from the applicant whether the applicant's submission is complete or incomplete. Failure to provide the applicant with this notice within 10 working days shall result in the submission being deemed complete for purposes of initiating the 60-day review period under this Section. If the submission is incomplete, the Department shall inform the applicant of the deficiencies with the submission in writing. If the submission is complete and the required fee, if any, has been paid, the Department shall approve or disapprove drawings and specifications submitted to the Department no later than 60 days following receipt by the Department. The drawings and specifications shall be of sufficient detail, as provided by Department rule, to enable

the Department to render a determination of compliance with design and construction standards under this Act. If the Department finds that the drawings are not of sufficient detail for it to render a determination of compliance, the plans shall be determined to be incomplete and shall not be considered for purposes of initiating the 60 day review period. If a submission of drawings and specifications is incomplete, the applicant may submit additional information. The 60-day review period shall not commence until the Department determines that a submission of drawings and specifications is complete or the submission is deemed complete. If the Department has not approved or disapproved the drawings and specifications within 60 days, the construction, major alteration, or addition shall be deemed approved. If the drawings and specifications are disapproved, the Department shall state in writing, with specificity, the reasons for the disapproval. The entity submitting the drawings and specifications may submit additional information in response to the written comments from the Department or request a reconsideration of the disapproval. A final decision of approval or disapproval shall be made within 45 days of the receipt of the additional information or reconsideration request. If denied, the Department shall state the specific reasons for the denial and the applicant may elect to seek dispute resolution pursuant to Section 25 of the Illinois Building Commission Act, which the Department must participate in.

(c) The Department shall provide written approval for occupancy pursuant to subsection (g) and shall not issue a violation to a facility as a result of a licensure or complaint survey based upon the facility's physical structure if:

(1) the Department reviewed and approved or deemed approved the drawing and specifications for compliance with design and construction standards;

(2) the construction, major alteration, or addition was built as submitted;

(3) the law or rules have not been amended since the original approval; and

(4) the conditions at the facility indicate that there is a reasonable degree of safety provided for the patients.

(c-5) The Department shall not issue a violation to a facility if the inspected aspects of the facility were previously found to be in compliance with applicable standards, the relevant law or rules have not been amended, conditions at the facility reasonably protect the safety of its patients, and alterations or new hazards have not been identified.

(d) The Department shall charge the following fees in connection with its reviews conducted before June 30, 2004 under this Section:

(1) (Blank).

(2) (Blank).

(3) If the estimated dollar value of the major construction is greater than $500,000, the fee shall be

established by the Department pursuant to rules that reflect the reasonable and direct cost of the Department in conducting the architectural reviews required under this Section. The estimated dollar value of the major construction subject to review under this Section shall be annually readjusted to reflect the increase in construction costs due to inflation.

The fees provided in this subsection (d) shall not apply to major construction projects involving facility changes that are required by Department rule amendments or to projects related to homeland security.

The fees provided in this subsection (d) shall also not apply to major construction projects if 51% or more of the estimated cost of the project is attributed to capital equipment. For major construction projects where 51% or more of the estimated cost of the project is attributed to capital equipment, the Department shall by rule establish a fee that is reasonably related to the cost of reviewing the project.

Disproportionate share hospitals and rural hospitals shall only pay one-half of the fees required in this subsection (d). For the purposes of this subsection (d), (i) "disproportionate share hospital" means a hospital described in items (1) through (5) of subsection (b) of Section 5-5.02 of the Illinois Public Aid Code and (ii) "rural hospital" means a hospital that is (A) located outside a metropolitan statistical area or (B) located 15 miles or less from a county that is outside a metropolitan

statistical area and is licensed to perform medical/surgical or obstetrical services and has a combined total bed capacity of 75 or fewer beds in these 2 service categories as of July 14, 1993, as determined by the Department.

The Department shall not commence the facility plan review process under this Section until the applicable fee has been paid.

(e) All fees received by the Department under this Section shall be deposited into the Health Facility Plan Review Fund, a special fund created in the State treasury. All fees paid by hospitals under subsection (d) shall be used only to cover the direct and reasonable costs relating to the Department's review of hospital projects under this Section. Moneys shall be appropriated from that Fund to the Department only to pay the costs of conducting reviews under this Section. None of the moneys in the Health Facility Plan Review Fund shall be used to reduce the amount of General Revenue Fund moneys appropriated to the Department for facility plan reviews conducted pursuant to this Section.

(f) (Blank).

(g) The Department shall conduct an on-site inspection of the completed project no later than 15 business days after notification from the applicant that the project has been completed and all certifications required by the Department have been received and accepted by the Department. The Department may extend this deadline only if a federally

mandated survey time frame takes precedence. The Department shall provide written approval for occupancy to the applicant within 5 working days of the Department's final inspection, provided the applicant has demonstrated substantial compliance as defined by Department rule. Occupancy of new major construction is prohibited until Department approval is received, unless the Department has not acted within the time frames provided in this subsection (g), in which case the construction shall be deemed approved. Occupancy shall be authorized after any required health inspection by the Department has been conducted.

(h) The Department shall establish, by rule, a procedure to conduct interim on-site review of large or complex construction projects.

(i) The Department shall establish, by rule, an expedited process for emergency repairs or replacement of like equipment.

(j) Nothing in this Section shall be construed to apply to maintenance, upkeep, or renovation that does not affect the structural integrity of the building, does not add beds or services over the number for which the facility is licensed, and provides a reasonable degree of safety for the patients.

(Source: P.A. 92-563, eff. 6-24-02; 92-803, eff. 8-16-02; 93-41, eff. 6-27-03.)

Section 10. The Illinois Public Aid Code is amended by changing Sections 5-5.4 and 5B-8 and adding Section 5-27 as

follows:

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

Sec. 5-5.4. Standards of Payment - Department of Healthcare and Family Services. The Department of Healthcare and Family Services shall develop standards of payment of 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, 2008, unless specifically provided for in this Section. The changes made by Public Act 93-841

extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

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

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

increase of 1.6% and, for services provided on or after October 1, 1999, shall be increased by $4.00 per resident-day, as defined by the Department.

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

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, a new payment methodology must be implemented for the nursing component of the rate effective July 1, 2003. The Department of Public Aid (now Healthcare and Family Services) shall develop the new payment methodology using the Minimum Data Set (MDS) as the instrument to collect information concerning nursing home resident condition necessary to compute the rate. The Department shall develop the new payment methodology to meet the unique needs of Illinois nursing home residents while remaining subject to the appropriations provided by the General Assembly. A transition period from the payment methodology in effect on June 30, 2003

to the payment methodology in effect on July 1, 2003 shall be provided for a period not exceeding 3 years and 184 days after implementation of the new payment methodology as follows:

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

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

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

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 numerator of the ratio used by the Department of Healthcare and Family Services to compute the rate payable under this Section using the Minimum Data Set (MDS) methodology shall incorporate the following annual amounts as the additional funds appropriated to the Department specifically to pay for rates based on the MDS nursing component methodology in excess of the funding in effect on December 31, 2006:

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

(ii) For rates taking effect October 1, 2007, $110,000,000.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the support component of the rates taking effect on October 1, 2007 shall be computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on 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 rates taking effect on July 1, 2004 shall be 3.0% greater than the rates in effect on June 30, 2004. These rates shall take effect only upon approval and implementation of the payment methodologies required under Section 5A-12.

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

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, a socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The socio-development component of the rate as of July 1, 2007 shall be increased by a factor of 2.53. The Illinois Department may by rule adjust these socio-development component rates, but

in no case may such rates be diminished.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or as long-term care facilities for residents under 22 years of age, the rates taking effect on July 1, 2003 shall include a statewide increase of 4%, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on October 1, 2007 shall include a statewide increase of 2.5%, as defined by the Department.

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

Rates established effective each July 1 shall govern

payment for services rendered throughout that fiscal year, except that rates established on July 1, 1996 shall be increased by 6.8% for services provided on or after January 1, 1997. Such rates will be based upon the rates calculated for the year beginning July 1, 1990, and for subsequent years thereafter until June 30, 2001 shall be based on the facility cost reports for the facility fiscal year ending at any point in time during the previous calendar year, updated to the midpoint of the rate year. The cost report shall be on file with the Department no later than April 1 of the current rate year. Should the cost report not be on file by April 1, the Department shall base the rate on the latest cost report filed by each skilled care facility and intermediate care facility, updated to the midpoint of the current rate year. In determining rates for services rendered on and after July 1, 1985, fixed time shall not be computed at less than zero. The Department shall not make any alterations of regulations which would reduce any component of the Medicaid rate to a level below what that component would have been utilizing in the rate effective on July 1, 1984.

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

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

(4) Shall take into account the actual costs incurred by facilities in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the U.S. Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

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

(Source: P.A. 94-48, eff. 7-1-05; 94-85, eff. 6-28-05; 94-697, eff. 11-21-05; 94-838, eff. 6-6-06; 94-964, eff. 6-28-06; 95-12, eff. 7-2-07.)

(305 ILCS 5/5-27 new)

Sec. 5-27. Pilot mandatory managed care program. To determine the potential for savings and improved quality of care in the Medicaid program, the Department shall implement in State fiscal year 2008 a pilot mandatory managed care program requiring recipients to enroll with a Managed Care Entity (MCE)

meeting the requirements of Section 1932 of the Social Security Act and under contract with the Department. The program shall be implemented in at least 2 contiguous counties with not less than 200,000 inhabitants and not more than 2,000,000 inhabitants. The program shall have the following features:

(1) All recipients in the selected counties who do not have eligibility through the spend-down program and who are not excluded from State plan based mandatory managed care by the Social Security Act shall be enrolled in the program.

(2) Only the following services may be excluded from the program and shall be delivered to eligible recipients through the fee-for-service system: nursing facility and assisted living long term care services, services provided through waivers granted pursuant to Sections 1115 and 1915 of the Social Security Act, and pharmacy services.

(3) Up to 3 Managed Care Entities shall be selected for the program.

(4) The Department must use the following criteria in selecting MCEs to participate in the pilot program: (A) network adequacy ensuring availability and access to care; (B) provider payment levels; (C) quality assurance plans including utilization management and peer review; (D) past performance on quality outcome measures (for example, the Health Plan Employer Data and Information Set (HEDIS)); (E) plan for care management; (F) data system adequacy, member

enrollment, and communication plan; and (G) any other criteria that the Department determines appropriate.

(5) The Department shall require that the MCEs in the pilot counties keep case-specific data under the pilot program and produce periodic and final reports based on that data of, at a minimum, the types and frequency of care provided to enrollees and the types and frequency of specialty and hospital care provided. The Department shall require case-specific data in a manner that does not violate applicable privacy laws.

(6) The Department shall perform an annual analysis of healthcare outcomes for the population served under the pilot program compared to healthcare outcomes for the medical assistance population enrolled in the primary care case management program under this Article. The Department shall present this analysis to the General Assembly no later than 60 days after the end of the month for which HEDIS measures are reported for the calendar year.

(305 ILCS 5/5B-8) (from Ch. 23, par. 5B-8)

Sec. 5B-8. Long-Term Care Provider Fund.

(a) There is created in the State Treasury the Long-Term Care Provider Fund. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

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

(1) For payments to skilled or intermediate nursing facilities, including county nursing facilities but excluding State-operated facilities, under Title XIX of the Social Security Act and Article V of this Code.

(2) For the reimbursement of moneys collected by the Illinois Department through error or mistake, and for making required payments under Section 5-4.38(a)(1) if there are no moneys available for such payments in the Medicaid Long Term Care Provider Participation Fee Trust Fund.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing the activities authorized by this Article.

(3.5) For reimbursement of expenses incurred by long-term care facilities, and payment of administrative expenses incurred by the Department of Public Health, in relation to the conduct and analysis of background checks for identified offenders under the Nursing Home Care Act.

(4) For payments of any amounts that are reimbursable to the federal government for payments from this Fund that are required to be paid by State warrant.

(5) For making transfers to the General Obligation Bond Retirement and Interest Fund, as those transfers are

authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

Disbursements from the Fund, other than transfers to the General Obligation Bond Retirement and Interest Fund, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the long-term care provider assessment imposed by this Article.

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

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(4) Any balance in the Medicaid Long Term Care Provider Participation Fee Fund in the State Treasury. The balance shall be transferred to the Fund upon certification by the Illinois Department to the State Comptroller that all of the disbursements required by Section 5-4.31(b) of this Code have been made.

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

(Source: P.A. 89-626, eff. 8-9-96.)

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