SB3290

LRB09620040KTG35543b

96TH GENERAL ASSEMBLY

State of Illinois

2009 and 2010

SB3290

Introduced 2/9/2010, by Sen. John M. Sullivan

SYNOPSIS AS INTRODUCED:

210 ILCS 3/30	
305 ILCS 5/5-2	from Ch. 23, par. 5-2
305 ILCS 5/5-5.5	from Ch. 23, par. 5-5.5
305 ILCS 5/12-8.2 new	
305 ILCS 5/5-5.8a rep.	
305 ILCS 5/5-22 rep.	

Amends the Alternative Health Care Delivery Act and the Illinois Public Aid Code. Creates the Medical Assistance Dental Reimbursement Revolving Fund, to be held by the Director of the Department of Healthcare and Family Services, outside of the State Treasury. Provides that the Fund shall contain all funds to pay for dental services provided by enrolled dental service providers for services to participants in the medical programs administered by the Department and any interest accrued by the Fund. Eliminates a provision requiring the Department, in cooperation with the Department of Public Health, to develop and implement a reimbursement methodology for all facilities participating in an alternative health care demonstration program. Eliminates a provision requiring the Department to adopt rules governing reimbursement for resident services provided by skilled nursing and intermediate care facilities. Repeals provisions providing that the Department shall tender payments for exceptional care to skilled nursing and intermediate care facilities only. Repeals provisions requiring the Department to submit a report concerning the Healthy Moms/Healthy Kids Program.

LRB096 20040 KTG 35543 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Alternative Health Care Delivery Act is amended by changing Section 30 as follows:

(210 ILCS 3/30)

Sec. 30. Demonstration program requirements. The requirements set forth in this Section shall apply to demonstration programs.

(a) There shall be no more than:

(i) 3 subacute care hospital alternative health care models in the City of Chicago (one of which shall be located on a designated site and shall have been licensed as a hospital under the Illinois Hospital Licensing Act within the 10 years immediately before the application for a license);

(ii) 2 subacute care hospital alternative health care models in the demonstration program for each of the following areas:

(1) Cook County outside the City of Chicago.

(2) DuPage, Kane, Lake, McHenry, and Will Counties.

(3) Municipalities with a population greater than

50,000 not located in the areas described in item (i) of subsection (a) and paragraphs (1) and (2) of item (ii) of subsection (a); and

(iii) 4 subacute care hospital alternative health care models in the demonstration program for rural areas.

In selecting among applicants for these licenses in rural areas, the Health Facilities and Services Review Board and the Department shall give preference to hospitals that may be unable for economic reasons to provide continued service to the community in which they are located unless the hospital were to receive an alternative health care model license.

(a-5) There shall be no more than the total number of postsurgical recovery care centers with a certificate of need for beds as of January 1, 2008.

(a-10) There shall be no more than a total of 9 children's respite care center alternative health care models in the demonstration program, which shall be located as follows:

(1) Two in the City of Chicago.

(2) One in Cook County outside the City of Chicago.

(3) A total of 2 in the area comprised of DuPage, Kane, Lake, McHenry, and Will counties.

(4) A total of 2 in municipalities with a population of 50,000 or more and not located in the areas described in paragraphs (1), (2), or (3).

(5) A total of 2 in rural areas, as defined by the Health Facilities and Services Review Board.

No more than one children's respite care model owned and operated by a licensed skilled pediatric facility shall be located in each of the areas designated in this subsection (a-10).

(a-15) There shall be 2 authorized community-based residential rehabilitation center alternative health care models in the demonstration program.

(a-20) There shall be an authorized Alzheimer's disease management center alternative health care model in the demonstration program. The Alzheimer's disease management center shall be located in Will County, owned by a not-for-profit entity, and endorsed by a resolution approved by the county board before the effective date of this amendatory Act of the 91st General Assembly.

(a-25) There shall be no more than 10 birth center alternative health care models in the demonstration program, located as follows:

(1) Four in the area comprising Cook, DuPage, Kane, Lake, McHenry, and Will counties, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(2) Three in municipalities with a population of 50,000 or more not located in the area described in paragraph (1) of this subsection, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

(3) Three in rural areas, one of which shall be owned or operated by a hospital and one of which shall be owned or operated by a federally qualified health center.

The first 3 birth centers authorized to operate by the Department shall be located in or predominantly serve the residents of a health professional shortage area as determined by the United States Department of Health and Human Services. There shall be no more than 2 birth centers authorized to operate in any single health planning area for obstetric services as determined under the Illinois Health Facilities Planning Act. If a birth center is located outside of a health professional shortage area, (i) the birth center shall be located in a health planning area with a demonstrated need for obstetrical service beds, as determined by the Health Facilities and Services Review Board or (ii) there must be a reduction in the existing number of obstetrical service beds in the planning area so that the establishment of the birth center does not result in an increase in the total number of obstetrical service beds in the health planning area.

(b) Alternative health care models, other than a model authorized under subsection (a-10) or ~~subsections (a-10) and~~ (a-20), shall obtain a certificate of need from the Health Facilities and Services Review Board under the Illinois Health Facilities Planning Act before receiving a license by the Department. If, after obtaining its initial certificate of need, an alternative health care delivery model that is a

community based residential rehabilitation center seeks to increase the bed capacity of that center, it must obtain a certificate of need from the Health Facilities and Services Review Board before increasing the bed capacity. Alternative health care models in medically underserved areas shall receive priority in obtaining a certificate of need.

(c) An alternative health care model license shall be issued for a period of one year and shall be annually renewed if the facility or program is in substantial compliance with the Department's rules adopted under this Act. A licensed alternative health care model that continues to be in substantial compliance after the conclusion of the demonstration program shall be eligible for annual renewals unless and until a different licensure program for that type of health care model is established by legislation, except that a postsurgical recovery care center meeting the following requirements may apply within 3 years after August 25, 2009 (the effective date of Public Act 96-669) ~~this amendatory Act of the 96th General Assembly~~ for a Certificate of Need permit to operate as a hospital:

(1) The postsurgical recovery care center shall apply to the Illinois Health Facilities Planning Board for a Certificate of Need permit to discontinue the postsurgical recovery care center and to establish a hospital.

(2) If the postsurgical recovery care center obtains a Certificate of Need permit to operate as a hospital, it

shall apply for licensure as a hospital under the Hospital Licensing Act and shall meet all statutory and regulatory requirements of a hospital.

(3) After obtaining licensure as a hospital, any license as an ambulatory surgical treatment center and any license as a post-surgical recovery care center shall be null and void.

(4) The former postsurgical recovery care center that receives a hospital license must seek and use its best efforts to maintain certification under Titles XVIII and XIX of the federal Social Security Act.

The Department may issue a provisional license to any alternative health care model that does not substantially comply with the provisions of this Act and the rules adopted under this Act if (i) the Department finds that the alternative health care model has undertaken changes and corrections which upon completion will render the alternative health care model in substantial compliance with this Act and rules and (ii) the health and safety of the patients of the alternative health care model will be protected during the period for which the provisional license is issued. The Department shall advise the licensee of the conditions under which the provisional license is issued, including the manner in which the alternative health care model fails to comply with the provisions of this Act and rules, and the time within which the changes and corrections necessary for the alternative health care model to

substantially comply with this Act and rules shall be completed.

(d) Alternative health care models shall seek certification under Titles XVIII and XIX of the federal Social Security Act. In addition, alternative health care models shall provide charitable care consistent with that provided by comparable health care providers in the geographic area.

(d-5) (Blank) ~~The Department of Healthcare and Family Services (formerly Illinois Department of Public Aid), in cooperation with the Illinois Department of Public Health, shall develop and implement a reimbursement methodology for all facilities participating in the demonstration program. The Department of Healthcare and Family Services shall keep a record of services provided under the demonstration program to recipients of medical assistance under the Illinois Public Aid Code and shall submit an annual report of that information to the Illinois Department of Public Health~~.

(e) Alternative health care models shall, to the extent possible, link and integrate their services with nearby health care facilities.

(f) Each alternative health care model shall implement a quality assurance program with measurable benefits and at reasonable cost.

(Source: P.A. 95-331, eff. 8-21-07; 95-445, eff. 1-1-08; 96-31, eff. 6-30-09; 96-129, eff. 8-4-09; 96-669, eff. 8-25-09; 96-812, eff. 1-1-10; revised 11-4-09.)

Section 10. The Illinois Public Aid Code is amended by changing Sections 5-2 and 5-5.5 and by adding Section 12-8.2 as follows:

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

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

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

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

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

either of the following requirements:

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size; or

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

(b) All persons who, excluding any eligibility requirements that are inconsistent with any federal

law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, would be determined eligible for such basic maintenance under Article IV by disregarding the maximum earned income permitted by federal law.

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

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

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

(b) The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 5(a) by April 1, 1990. Such plan shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 133% of the nonfarm

income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

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

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

7. Persons who are under 21 years of age and would qualify as disabled as defined under the Federal

Supplemental Security Income Program, provided medical service for such persons would be eligible for Federal Financial Participation, and provided the Illinois Department determines that:

(a) the person requires a level of care provided by a hospital, skilled nursing facility, or intermediate care facility, as determined by a physician licensed to practice medicine in all its branches;

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

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

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

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

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

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

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

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

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

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

permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

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

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

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

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

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

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

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

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

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the

coverage under this paragraph 12 within 30 days after the effective date of this amendatory Act of the 92nd General Assembly.

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

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department

of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

(a) A caretaker relative who is 19 years of age or older when countable income is at or below 185% of the Federal Poverty Level Guidelines, as published annually in the Federal Register, for the appropriate family size. A person may not spend down to become eligible under this paragraph 15.

(b) Eligibility shall be reviewed annually.

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

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

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

(f) Individuals shall have a grace period through 30 days ~~the month~~ of coverage to pay the premium.

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

termination of coverage.

(h) Partial premium payments shall not be refunded.

(i) Following termination of an individual's coverage under this paragraph 15, the following action is required before the individual can be re-enrolled:

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

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

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

The Department is authorized to implement the provisions of this amendatory Act of the 95th General Assembly by adopting the medical assistance rules in effect as of October 1, 2007, at 89 Ill. Admin. Code 125, and at 89 Ill. Admin. Code 120.32 along with only those changes necessary to conform to federal Medicaid requirements, federal laws, and federal regulations, including but not limited to Section 1931 of the Social Security Act (42

U.S.C. Sec. 1396u-1), as interpreted by the U.S. Department of Health and Human Services, and the countable income eligibility standard authorized by this paragraph 15. The Department may not otherwise adopt any rule to implement this increase except as authorized by law, to meet the eligibility standards authorized by the federal government in the Medicaid State Plan or the Title XXI Plan, or to meet an order from the federal government or any court.

16. ~~15.~~ Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16 ~~15~~, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16 ~~15~~. Such persons shall be eligible for medical assistance under this paragraph 16 ~~15~~ for so long as they need treatment for the cancer. A person shall be considered

to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or testicular cancer, including recurrent metastatic cancer that is a known or presumed complication of prostate or testicular cancer and complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need treatment. "Medical assistance" under this paragraph 16 ~~15~~ shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a claim against the estate of a deceased recipient of services under this paragraph 16 ~~15~~ and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16 ~~15~~.

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

Department is provided with express statutory authority.

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

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

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

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor

members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

(Source: P.A. 95-546, eff. 8-29-07; 95-1055, eff. 4-10-09; 96-20, eff. 6-30-09; 96-181, eff. 8-10-09; 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; revised 9-25-09.)

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

Sec. 5-5.5. Elements of Payment Rate.

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

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

(2) Resident Services, with the cost of this component being determined by taking into account the actual costs, needs and utilization of these services, as derived from an assessment of the resident needs in the nursing facilities. ~~The Department shall adopt rules governing reimbursement for resident services as listed in Section 5-1.1. Surveys or assessments of resident needs under this Section shall include a review by the facility of the results of such assessments and a discussion of issues in dispute with~~

~~authorized survey staff, unless the facility elects not to participate in such a review process. Surveys or assessments of resident needs under this Section may be conducted semi-annually and payment rates relating to resident services may be changed on a semi annual basis. The Illinois Department shall initiate a project, either on a pilot basis or Statewide, to reimburse the cost of resident services based on a methodology which utilizes an assessment of resident needs to determine the level of reimbursement. This methodology shall be different from the payment criteria for resident services utilized by the Illinois Department on July 1, 1981. On March 1, 1982, and each year thereafter, until such time when the Illinois Department adopts the methodology used in such project for use statewide, the Illinois Department shall report to the General Assembly on the implementation and progress of such project. The report shall include:~~

~~(A) A statement of the Illinois Department's goals and objectives for such project;~~

~~(B) A description of such project, including the number and type of nursing facilities involved in the project;~~

~~(C) A description of the methodology used in such project;~~

~~(D) A description of the Illinois Department's application of the methodology;~~

~~(E) A statement on the methodology's effect on the quality of care given to residents in the sample nursing facilities; and~~

~~(F) A statement on the cost of the methodology used in such project and a comparison of this cost with the cost of the current payment criteria.~~

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

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

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

(b) In developing a prospective method for determining

payment rates for skilled nursing and intermediate care services in nursing facilities, the Department of Healthcare and Family Services shall consider the following cost elements:

(1) Reasonable capital cost determined by utilizing incurred interest rate and the current value of the investment, including land, utilizing composite rates, or by utilizing such other reasonable cost related methods determined by the Department. However, beginning with the rate reimbursement period effective July 1, 1987, the Department shall be prohibited from establishing, including, and implementing any depreciation factor in calculating the capital cost element.

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

(c) The Illinois Department may implement the amendatory changes to this Section made by this amendatory Act of 1991 through the use of emergency rules in accordance with the provisions of Section 5.02 of the Illinois Administrative Procedure Act. For purposes of the Illinois Administrative Procedure Act, the adoption of rules to implement the amendatory changes to this Section made by this amendatory Act

of 1991 shall be deemed an emergency and necessary for the public interest, safety and welfare.

(d) No later than January 1, 2001, the Department of Public Aid shall file with the Joint Committee on Administrative Rules, pursuant to the Illinois Administrative Procedure Act, a proposed rule, or a proposed amendment to an existing rule, regarding payment for appropriate services, including assessment, care planning, discharge planning, and treatment provided by nursing facilities to residents who have a serious mental illness.

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

(305 ILCS 5/12-8.2 new)

Sec. 12-8.2. Medical Assistance Dental Reimbursement Revolving Fund. There is created a revolving fund to be known as the Medical Assistance Dental Reimbursement Revolving Fund, to be held by the Director of the Department of Healthcare and Family Services, outside of the State Treasury, for the following purposes:

(1) The deposit of all funds to pay for dental services provided by enrolled dental service providers for services to participants in the medical programs administered by the Department.

(2) The deposit of any interest accrued by the revolving fund, which interest shall be available to pay for dental services provided by enrolled dental service

providers for services to participants in the medical programs administered by the Department.

(3) The payment of amounts to enrolled dental service providers for dental services provided to participants in the medical programs administered by the Department.

(305 ILCS 5/5-5.8a rep.)

(305 ILCS 5/5-22 rep.)

Section 15. The Illinois Public Aid Code is amended by repealing Sections 5-5.8a and 5-22.