



## 100TH GENERAL ASSEMBLY

### State of Illinois

2017 and 2018

SB1386

Introduced 2/9/2017, by Sen. Kimberly A. Lightford

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5e.1	
305 ILCS 5/5A-2	from Ch. 23, par. 5A-2
305 ILCS 5/5A-5	from Ch. 23, par. 5A-5
305 ILCS 5/5A-8	from Ch. 23, par. 5A-8
305 ILCS 5/5A-10	from Ch. 23, par. 5A-10
305 ILCS 5/5A-12.5	
305 ILCS 5/5A-14	
305 ILCS 5/12-4.105	
305 ILCS 5/14-12	

Amends the Hospital Provider Funding Article of the Illinois Public Aid Code. Extends the period of time certain hospital assessments are imposed through State fiscal year 2020. Effective July 1, 2017.

LRB100 08643 KTG 18777 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by  
5 changing Sections 5-5e.1, 5A-2, 5A-5, 5A-8, 5A-10, 5A-12.5,  
6 5A-14, 12-4.105, and 14-12 as follows:

7 (305 ILCS 5/5-5e.1)

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

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

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

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

15 (3) meets one of the following:

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

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

19 (b) Definitions. As used in this Section:

20 (1) "Charity percent" means the ratio of (i) the  
21 hospital's charity charges for services provided to  
22 individuals without health insurance or another source of  
23 third party coverage to (ii) the Illinois total hospital

1 charges, each as reported on the hospital's OBRA form.

2 (2) "MIUR" means Medicaid Inpatient Utilization Rate  
3 and is defined as a fraction, the numerator of which is the  
4 number of a hospital's inpatient days provided in the  
5 hospital's fiscal year ending 3 years prior to the rate  
6 year, to patients who, for such days, were eligible for  
7 Medicaid under Title XIX of the federal Social Security  
8 Act, 42 USC 1396a et seq., excluding those persons eligible  
9 for medical assistance pursuant to 42 U.S.C.  
10 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of  
11 Section 5-2 of this Article, and the denominator of which  
12 is the total number of the hospital's inpatient days in  
13 that same period, excluding those persons eligible for  
14 medical assistance pursuant to 42 U.S.C.  
15 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of  
16 Section 5-2 of this Article.

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

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

21 (c) Beginning July 1, 2012 and ending on June 30, 2020  
22 ~~2018~~, a hospital that would have qualified for the rate year  
23 beginning October 1, 2011, shall be a Safety-Net Hospital.

24 (d) No later than August 15 preceding the rate year, each  
25 hospital shall submit the OBRA form to the Department. Prior to  
26 October 1, the Department shall notify each hospital whether it

1 has qualified as a Safety-Net Hospital.

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

4 (f) Nothing in this Section shall be construed as limiting  
5 the ability of the Department to include the Safety-Net  
6 Hospitals in the hospital rate reform mandated by Section 14-11  
7 of this Code and implemented under Section 14-12 of this Code  
8 and by administrative rulemaking.

9 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;  
10 98-651, eff. 6-16-14.)

11 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

12 (Section scheduled to be repealed on July 1, 2018)

13 Sec. 5A-2. Assessment.

14 (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal  
15 years 2009 through 2020 ~~2018~~, an annual assessment on inpatient  
16 services is imposed on each hospital provider in an amount  
17 equal to \$218.38 multiplied by the difference of the hospital's  
18 occupied bed days less the hospital's Medicare bed days,  
19 provided, however, that the amount of \$218.38 shall be  
20 increased by a uniform percentage to generate an amount equal  
21 to 75% of the State share of the payments authorized under  
22 Section 5A-12.5, with such increase only taking effect upon the  
23 date that a State share for such payments is required under  
24 federal law. For the period of April through June 2015, the  
25 amount of \$218.38 used to calculate the assessment under this

1 paragraph shall, by emergency rule under subsection (s) of  
2 Section 5-45 of the Illinois Administrative Procedure Act, be  
3 increased by a uniform percentage to generate \$20,250,000 in  
4 the aggregate for that period from all hospitals subject to the  
5 annual assessment under this paragraph.

6 (2) In addition to any other assessments imposed under this  
7 Article, effective July 1, 2016 and semi-annually thereafter  
8 through June 2020 ~~2018~~, in addition to any federally required  
9 State share as authorized under paragraph (1), the amount of  
10 \$218.38 shall be increased by a uniform percentage to generate  
11 an amount equal to 75% of the ACA Assessment Adjustment, as  
12 defined in subsection (b-6) of this Section.

13 For State fiscal years 2009 through 2020 ~~2014~~ and after, a  
14 hospital's occupied bed days and Medicare bed days shall be  
15 determined using the most recent data available from each  
16 hospital's 2005 Medicare cost report as contained in the  
17 Healthcare Cost Report Information System file, for the quarter  
18 ending on December 31, 2006, without regard to any subsequent  
19 adjustments or changes to such data. If a hospital's 2005  
20 Medicare cost report is not contained in the Healthcare Cost  
21 Report Information System, then the Illinois Department may  
22 obtain the hospital provider's occupied bed days and Medicare  
23 bed days from any source available, including, but not limited  
24 to, records maintained by the hospital provider, which may be  
25 inspected at all times during business hours of the day by the  
26 Illinois Department or its duly authorized agents and

1 employees.

2 (b) (Blank).

3 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the  
4 portion of State fiscal year 2012, beginning June 10, 2012  
5 through June 30, 2012, and for State fiscal years 2013 through  
6 2020 ~~2018~~, an annual assessment on outpatient services is  
7 imposed on each hospital provider in an amount equal to .008766  
8 multiplied by the hospital's outpatient gross revenue,  
9 provided, however, that the amount of .008766 shall be  
10 increased by a uniform percentage to generate an amount equal  
11 to 25% of the State share of the payments authorized under  
12 Section 5A-12.5, with such increase only taking effect upon the  
13 date that a State share for such payments is required under  
14 federal law. For the period beginning June 10, 2012 through  
15 June 30, 2012, the annual assessment on outpatient services  
16 shall be prorated by multiplying the assessment amount by a  
17 fraction, the numerator of which is 21 days and the denominator  
18 of which is 365 days. For the period of April through June  
19 2015, the amount of .008766 used to calculate the assessment  
20 under this paragraph shall, by emergency rule under subsection  
21 (s) of Section 5-45 of the Illinois Administrative Procedure  
22 Act, be increased by a uniform percentage to generate  
23 \$6,750,000 in the aggregate for that period from all hospitals  
24 subject to the annual assessment under this paragraph.

25 (2) In addition to any other assessments imposed under this  
26 Article, effective July 1, 2016 and semi-annually thereafter

1 through June 2020 ~~2018~~, in addition to any federally required  
2 State share as authorized under paragraph (1), the amount of  
3 .008766 shall be increased by a uniform percentage to generate  
4 an amount equal to 25% of the ACA Assessment Adjustment, as  
5 defined in subsection (b-6) of this Section.

6 For the portion of State fiscal year 2012, beginning June  
7 10, 2012 through June 30, 2012, and State fiscal years 2013  
8 through 2020 ~~2018~~, a hospital's outpatient gross revenue shall  
9 be determined using the most recent data available from each  
10 hospital's 2009 Medicare cost report as contained in the  
11 Healthcare Cost Report Information System file, for the quarter  
12 ending on June 30, 2011, without regard to any subsequent  
13 adjustments or changes to such data. If a hospital's 2009  
14 Medicare cost report is not contained in the Healthcare Cost  
15 Report Information System, then the Department may obtain the  
16 hospital provider's outpatient gross revenue from any source  
17 available, including, but not limited to, records maintained by  
18 the hospital provider, which may be inspected at all times  
19 during business hours of the day by the Department or its duly  
20 authorized agents and employees.

21 (b-6) (1) As used in this Section, "ACA Assessment  
22 Adjustment" means:

23 (A) For the period of July 1, 2016 through December 31,  
24 2016, the product of .19125 multiplied by the sum of the  
25 fee-for-service payments to hospitals as authorized under  
26 Section 5A-12.5 and the adjustments authorized under

1 subsection (t) of Section 5A-12.2 to managed care  
2 organizations for hospital services due and payable in the  
3 month of April 2016 multiplied by 6.

4 (B) For the period of January 1, 2017 through June 30,  
5 2017, the product of .19125 multiplied by the sum of the  
6 fee-for-service payments to hospitals as authorized under  
7 Section 5A-12.5 and the adjustments authorized under  
8 subsection (t) of Section 5A-12.2 to managed care  
9 organizations for hospital services due and payable in the  
10 month of October 2016 multiplied by 6, except that the  
11 amount calculated under this subparagraph (B) shall be  
12 adjusted, either positively or negatively, to account for  
13 the difference between the actual payments issued under  
14 Section 5A-12.5 for the period beginning July 1, 2016  
15 through December 31, 2016 and the estimated payments due  
16 and payable in the month of April 2016 multiplied by 6 as  
17 described in subparagraph (A).

18 (C) For the period of July 1, 2017 through December 31,  
19 2017, the product of .19125 multiplied by the sum of the  
20 fee-for-service payments to hospitals as authorized under  
21 Section 5A-12.5 and the adjustments authorized under  
22 subsection (t) of Section 5A-12.2 to managed care  
23 organizations for hospital services due and payable in the  
24 month of April 2017 multiplied by 6, except that the amount  
25 calculated under this subparagraph (C) shall be adjusted,  
26 either positively or negatively, to account for the



1 difference between the actual payments issued under  
2 Section 5A-12.5 for the period beginning January 1, 2017  
3 through June 30, 2017 and the estimated payments due and  
4 payable in the month of October 2016 multiplied by 6 as  
5 described in subparagraph (B).

6 (D) For the period of January 1, 2018 through June 30,  
7 2018, the product of .19125 multiplied by the sum of the  
8 fee-for-service payments to hospitals as authorized under  
9 Section 5A-12.5 and the adjustments authorized under  
10 subsection (t) of Section 5A-12.2 to managed care  
11 organizations for hospital services due and payable in the  
12 month of October 2017 multiplied by 6, except that:

13 (i) the amount calculated under this subparagraph

14 (D) shall be adjusted, either positively or  
15 negatively, to account for the difference between the  
16 actual payments issued under Section 5A-12.5 for the  
17 period of July 1, 2017 through December 31, 2017 and  
18 the estimated payments due and payable in the month of  
19 April 2017 multiplied by 6 as described in subparagraph  
20 (C); and

21 (ii) the amount calculated under this subparagraph

22 (D) shall be adjusted to include the product of .19125  
23 multiplied by the sum of the fee-for-service payments,  
24 if any, estimated to be paid to hospitals under  
25 subsection (b) of Section 5A-12.5.

26 (1.5) Subject to federal approval, payments made under

1 subparagraphs (A), (B), (C), and (D) shall continue through  
2 December 31, 2019.

3 (2) The Department shall complete and apply a final  
4 reconciliation of the ACA Assessment Adjustment prior to June  
5 30, 2018 to account for:

6 (A) any differences between the actual payments issued  
7 or scheduled to be issued prior to June 30, 2018 as  
8 authorized in Section 5A-12.5 for the period of January 1,  
9 2018 through June 30, 2020 ~~2018~~ and the estimated payments  
10 due and payable in the month of October 2017 multiplied by  
11 6 as described in subparagraph (D); and

12 (B) any difference between the estimated  
13 fee-for-service payments under subsection (b) of Section  
14 5A-12.5 and the amount of such payments that are actually  
15 scheduled to be paid.

16 The Department shall notify hospitals of any additional  
17 amounts owed or reduction credits to be applied to the June  
18 2018 ACA Assessment Adjustment. This is to be considered the  
19 final reconciliation for the ACA Assessment Adjustment.

20 (3) Notwithstanding any other provision of this Section, if  
21 for any reason the scheduled payments under subsection (b) of  
22 Section 5A-12.5 are not issued in full by the final day of the  
23 period authorized under subsection (b) of Section 5A-12.5,  
24 funds collected from each hospital pursuant to subparagraph (D)  
25 of paragraph (1) and pursuant to paragraph (2), attributable to  
26 the scheduled payments authorized under subsection (b) of

1 Section 5A-12.5 that are not issued in full by the final day of  
2 the period attributable to each payment authorized under  
3 subsection (b) of Section 5A-12.5, shall be refunded.

4 (4) The increases authorized under paragraph (2) of  
5 subsection (a) and paragraph (2) of subsection (b-5) shall be  
6 limited to the federally required State share of the total  
7 payments authorized under Section 5A-12.5 if the sum of such  
8 payments yields an annualized amount equal to or less than  
9 \$450,000,000, or if the adjustments authorized under  
10 subsection (t) of Section 5A-12.2 are found not to be  
11 actuarially sound; however, this limitation shall not apply to  
12 the fee-for-service payments described in subsection (b) of  
13 Section 5A-12.5.

14 (c) (Blank).

15 (d) Notwithstanding any of the other provisions of this  
16 Section, the Department is authorized to adopt rules to reduce  
17 the rate of any annual assessment imposed under this Section,  
18 as authorized by Section 5-46.2 of the Illinois Administrative  
19 Procedure Act.

20 (e) Notwithstanding any other provision of this Section,  
21 any plan providing for an assessment on a hospital provider as  
22 a permissible tax under Title XIX of the federal Social  
23 Security Act and Medicaid-eligible payments to hospital  
24 providers from the revenues derived from that assessment shall  
25 be reviewed by the Illinois Department of Healthcare and Family  
26 Services, as the Single State Medicaid Agency required by

1 federal law, to determine whether those assessments and  
2 hospital provider payments meet federal Medicaid standards. If  
3 the Department determines that the elements of the plan may  
4 meet federal Medicaid standards and a related State Medicaid  
5 Plan Amendment is prepared in a manner and form suitable for  
6 submission, that State Plan Amendment shall be submitted in a  
7 timely manner for review by the Centers for Medicare and  
8 Medicaid Services of the United States Department of Health and  
9 Human Services and subject to approval by the Centers for  
10 Medicare and Medicaid Services of the United States Department  
11 of Health and Human Services. No such plan shall become  
12 effective without approval by the Illinois General Assembly by  
13 the enactment into law of related legislation. Notwithstanding  
14 any other provision of this Section, the Department is  
15 authorized to adopt rules to reduce the rate of any annual  
16 assessment imposed under this Section. Any such rules may be  
17 adopted by the Department under Section 5-50 of the Illinois  
18 Administrative Procedure Act.

19 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-2,  
20 eff. 3-26-15; 99-516, eff. 6-30-16.)

21 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)

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

23 (a) The Illinois Department shall send a notice of  
24 assessment to every hospital provider subject to assessment  
25 under this Article. The notice of assessment shall notify the

1 hospital of its assessment and shall be sent after receipt by  
2 the Department of notification from the Centers for Medicare  
3 and Medicaid Services of the U.S. Department of Health and  
4 Human Services that the payment methodologies required under  
5 this Article and, if necessary, the waiver granted under 42 CFR  
6 433.68 have been approved. The notice shall be on a form  
7 prepared by the Illinois Department and shall state the  
8 following:

9 (1) The name of the hospital provider.

10 (2) The address of the hospital provider's principal  
11 place of business from which the provider engages in the  
12 occupation of hospital provider in this State, and the name  
13 and address of each hospital operated, conducted, or  
14 maintained by the provider in this State.

15 (3) The occupied bed days, occupied bed days less  
16 Medicare days, adjusted gross hospital revenue, or  
17 outpatient gross revenue of the hospital provider  
18 (whichever is applicable), the amount of assessment  
19 imposed under Section 5A-2 for the State fiscal year for  
20 which the notice is sent, and the amount of each  
21 installment to be paid during the State fiscal year.

22 (4) (Blank).

23 (5) Other reasonable information as determined by the  
24 Illinois Department.

25 (b) If a hospital provider conducts, operates, or maintains  
26 more than one hospital licensed by the Illinois Department of

1 Public Health, the provider shall pay the assessment for each  
2 hospital separately.

3 (c) Notwithstanding any other provision in this Article, in  
4 the case of a person who ceases to conduct, operate, or  
5 maintain a hospital in respect of which the person is subject  
6 to assessment under this Article as a hospital provider, the  
7 assessment for the State fiscal year in which the cessation  
8 occurs shall be adjusted by multiplying the assessment computed  
9 under Section 5A-2 by a fraction, the numerator of which is the  
10 number of days in the year during which the provider conducts,  
11 operates, or maintains the hospital and the denominator of  
12 which is 365. Immediately upon ceasing to conduct, operate, or  
13 maintain a hospital, the person shall pay the assessment for  
14 the year as so adjusted (to the extent not previously paid).

15 (d) Notwithstanding any other provision in this Article, a  
16 provider who commences conducting, operating, or maintaining a  
17 hospital, upon notice by the Illinois Department, shall pay the  
18 assessment computed under Section 5A-2 and subsection (e) in  
19 installments on the due dates stated in the notice and on the  
20 regular installment due dates for the State fiscal year  
21 occurring after the due dates of the initial notice.

22 (e) Notwithstanding any other provision in this Article,  
23 for State fiscal years 2009 through 2020 ~~2018~~, in the case of a  
24 hospital provider that did not conduct, operate, or maintain a  
25 hospital in 2005, the assessment for that State fiscal year  
26 shall be computed on the basis of hypothetical occupied bed

1 days for the full calendar year as determined by the Illinois  
2 Department. Notwithstanding any other provision in this  
3 Article, for the portion of State fiscal year 2012 beginning  
4 June 10, 2012 through June 30, 2012, and for State fiscal years  
5 2013 through 2020 ~~2018~~, in the case of a hospital provider that  
6 did not conduct, operate, or maintain a hospital in 2009, the  
7 assessment under subsection (b-5) of Section 5A-2 for that  
8 State fiscal year shall be computed on the basis of  
9 hypothetical gross outpatient revenue for the full calendar  
10 year as determined by the Illinois Department.

11 (f) Every hospital provider subject to assessment under  
12 this Article shall keep sufficient records to permit the  
13 determination of adjusted gross hospital revenue for the  
14 hospital's fiscal year. All such records shall be kept in the  
15 English language and shall, at all times during regular  
16 business hours of the day, be subject to inspection by the  
17 Illinois Department or its duly authorized agents and  
18 employees.

19 (g) The Illinois Department may, by rule, provide a  
20 hospital provider a reasonable opportunity to request a  
21 clarification or correction of any clerical or computational  
22 errors contained in the calculation of its assessment, but such  
23 corrections shall not extend to updating the cost report  
24 information used to calculate the assessment.

25 (h) (Blank).

26 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;

1 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.  
2 7-20-15.)

3 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)  
4 Sec. 5A-8. Hospital Provider Fund.

5 (a) There is created in the State Treasury the Hospital  
6 Provider Fund. Interest earned by the Fund shall be credited to  
7 the Fund. The Fund shall not be used to replace any moneys  
8 appropriated to the Medicaid program by the General Assembly.

9 (b) The Fund is created for the purpose of receiving moneys  
10 in accordance with Section 5A-6 and disbursing moneys only for  
11 the following purposes, notwithstanding any other provision of  
12 law:

13 (1) For making payments to hospitals as required under  
14 this Code, under the Children's Health Insurance Program  
15 Act, under the Covering ALL KIDS Health Insurance Act, and  
16 under the Long Term Acute Care Hospital Quality Improvement  
17 Transfer Program Act.

18 (2) For the reimbursement of moneys collected by the  
19 Illinois Department from hospitals or hospital providers  
20 through error or mistake in performing the activities  
21 authorized under this Code.

22 (3) For payment of administrative expenses incurred by  
23 the Illinois Department or its agent in performing  
24 activities under this Code, under the Children's Health  
25 Insurance Program Act, under the Covering ALL KIDS Health



1 Insurance Act, and under the Long Term Acute Care Hospital  
2 Quality Improvement Transfer Program Act.

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

6 (5) For making transfers, as those transfers are  
7 authorized in the proceedings authorizing debt under the  
8 Short Term Borrowing Act, but transfers made under this  
9 paragraph (5) shall not exceed the principal amount of debt  
10 issued in anticipation of the receipt by the State of  
11 moneys to be deposited into the Fund.

12 (6) For making transfers to any other fund in the State  
13 treasury, but transfers made under this paragraph (6) shall  
14 not exceed the amount transferred previously from that  
15 other fund into the Hospital Provider Fund plus any  
16 interest that would have been earned by that fund on the  
17 monies that had been transferred.

18 (6.5) For making transfers to the Healthcare Provider  
19 Relief Fund, except that transfers made under this  
20 paragraph (6.5) shall not exceed \$60,000,000 in the  
21 aggregate.

22 (7) For making transfers not exceeding the following  
23 amounts, related to State fiscal years 2013 through 2020  
24 ~~2018~~, to the following designated funds:

25 Health and Human Services Medicaid Trust  
26 Fund ..... \$20,000,000

1 Long-Term Care Provider Fund ..... \$30,000,000

2 General Revenue Fund ..... \$80,000,000.

3 Transfers under this paragraph shall be made within 7 days  
4 after the payments have been received pursuant to the  
5 schedule of payments provided in subsection (a) of Section  
6 5A-4.

7 (7.1) (Blank).

8 (7.5) (Blank).

9 (7.8) (Blank).

10 (7.9) (Blank).

11 (7.10) For State fiscal year 2014, for making transfers  
12 of the moneys resulting from the assessment under  
13 subsection (b-5) of Section 5A-2 and received from hospital  
14 providers under Section 5A-4 and transferred into the  
15 Hospital Provider Fund under Section 5A-6 to the designated  
16 funds not exceeding the following amounts in that State  
17 fiscal year:

18 Health Care Provider Relief Fund .... \$100,000,000

19 Transfers under this paragraph shall be made within 7  
20 days after the payments have been received pursuant to the  
21 schedule of payments provided in subsection (a) of Section  
22 5A-4.

23 The additional amount of transfers in this paragraph  
24 (7.10), authorized by Public Act 98-651, shall be made  
25 within 10 State business days after June 16, 2014 (the  
26 effective date of Public Act 98-651). That authority shall

1 remain in effect even if Public Act 98-651 does not become  
2 law until State fiscal year 2015.

3 (7.10a) For State fiscal years 2015 through 2020 ~~2018~~,  
4 for making transfers of the moneys resulting from the  
5 assessment under subsection (b-5) of Section 5A-2 and  
6 received from hospital providers under Section 5A-4 and  
7 transferred into the Hospital Provider Fund under Section  
8 5A-6 to the designated funds not exceeding the following  
9 amounts related to each State fiscal year:

10 Health Care Provider Relief Fund . . . . \$50,000,000

11 Transfers under this paragraph shall be made within 7  
12 days after the payments have been received pursuant to the  
13 schedule of payments provided in subsection (a) of Section  
14 5A-4.

15 (7.11) (Blank).

16 (7.12) For State fiscal year 2013, for increasing by  
17 21/365ths the transfer of the moneys resulting from the  
18 assessment under subsection (b-5) of Section 5A-2 and  
19 received from hospital providers under Section 5A-4 for the  
20 portion of State fiscal year 2012 beginning June 10, 2012  
21 through June 30, 2012 and transferred into the Hospital  
22 Provider Fund under Section 5A-6 to the designated funds  
23 not exceeding the following amounts in that State fiscal  
24 year:

25 Health Care Provider Relief Fund . . . . . \$2,870,000

26 Since the federal Centers for Medicare and Medicaid

1 Services approval of the assessment authorized under  
2 subsection (b-5) of Section 5A-2, received from hospital  
3 providers under Section 5A-4 and the payment methodologies  
4 to hospitals required under Section 5A-12.4 was not  
5 received by the Department until State fiscal year 2014 and  
6 since the Department made retroactive payments during  
7 State fiscal year 2014 related to the referenced period of  
8 June 2012, the transfer authority granted in this paragraph  
9 (7.12) is extended through the date that is 10 State  
10 business days after June 16, 2014 (the effective date of  
11 Public Act 98-651).

12 (7.13) In addition to any other transfers authorized  
13 under this Section, for State fiscal years 2017 and 2020  
14 ~~2018~~, for making transfers to the Healthcare Provider  
15 Relief Fund of moneys collected from the ACA Assessment  
16 Adjustment authorized under subsections (a) and (b-5) of  
17 Section 5A-2 and paid by hospital providers under Section  
18 5A-4 into the Hospital Provider Fund under Section 5A-6 for  
19 each State fiscal year. Timing of transfers to the  
20 Healthcare Provider Relief Fund under this paragraph shall  
21 be at the discretion of the Department, but no less  
22 frequently than quarterly.

23 (8) For making refunds to hospital providers pursuant  
24 to Section 5A-10.

25 (9) For making payment to capitated managed care  
26 organizations as described in subsections (s) and (t) of

1 Section 5A-12.2 of this Code.

2 Disbursements from the Fund, other than transfers  
3 authorized under paragraphs (5) and (6) of this subsection,  
4 shall be by warrants drawn by the State Comptroller upon  
5 receipt of vouchers duly executed and certified by the Illinois  
6 Department.

7 (c) The Fund shall consist of the following:

8 (1) All moneys collected or received by the Illinois  
9 Department from the hospital provider assessment imposed  
10 by this Article.

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

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

17 (3.5) As applicable, proceeds from surety bond  
18 payments payable to the Department as referenced in  
19 subsection (s) of Section 5A-12.2 of this Code.

20 (4) Moneys transferred from another fund in the State  
21 treasury.

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

24 (d) (Blank).

25 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;  
26 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.

1 7-20-15; 99-516, eff. 6-30-16.)

2 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

3 Sec. 5A-10. Applicability.

4 (a) The assessment imposed by subsection (a) of Section  
5 5A-2 shall cease to be imposed and the Department's obligation  
6 to make payments shall immediately cease, and any moneys  
7 remaining in the Fund shall be refunded to hospital providers  
8 in proportion to the amounts paid by them, if:

9 (1) The payments to hospitals required under this  
10 Article are not eligible for federal matching funds under  
11 Title XIX or XXI of the Social Security Act;

12 (2) For State fiscal years 2009 through 2020 ~~2018~~, the  
13 Department of Healthcare and Family Services adopts any  
14 administrative rule change to reduce payment rates or  
15 alters any payment methodology that reduces any payment  
16 rates made to operating hospitals under the approved Title  
17 XIX or Title XXI State plan in effect January 1, 2008  
18 except for:

19 (A) any changes for hospitals described in  
20 subsection (b) of Section 5A-3;

21 (B) any rates for payments made under this Article  
22 V-A;

23 (C) any changes proposed in State plan amendment  
24 transmittal numbers 08-01, 08-02, 08-04, 08-06, and  
25 08-07;

1 (D) in relation to any admissions on or after  
2 January 1, 2011, a modification in the methodology for  
3 calculating outlier payments to hospitals for  
4 exceptionally costly stays, for hospitals reimbursed  
5 under the diagnosis-related grouping methodology in  
6 effect on July 1, 2011; provided that the Department  
7 shall be limited to one such modification during the  
8 36-month period after the effective date of this  
9 amendatory Act of the 96th General Assembly;

10 (E) any changes affecting hospitals authorized by  
11 Public Act 97-689;

12 (F) any changes authorized by Section 14-12 of this  
13 Code, or for any changes authorized under Section 5A-15  
14 of this Code; or

15 (G) any changes authorized under Section 5-5b.1.

16 (b) The assessment imposed by Section 5A-2 shall not take  
17 effect or shall cease to be imposed, and the Department's  
18 obligation to make payments shall immediately cease, if the  
19 assessment is determined to be an impermissible tax under Title  
20 XIX of the Social Security Act. Moneys in the Hospital Provider  
21 Fund derived from assessments imposed prior thereto shall be  
22 disbursed in accordance with Section 5A-8 to the extent federal  
23 financial participation is not reduced due to the  
24 impermissibility of the assessments, and any remaining moneys  
25 shall be refunded to hospital providers in proportion to the  
26 amounts paid by them.

1           (c) The assessments imposed by subsection (b-5) of Section  
2 5A-2 shall not take effect or shall cease to be imposed, the  
3 Department's obligation to make payments shall immediately  
4 cease, and any moneys remaining in the Fund shall be refunded  
5 to hospital providers in proportion to the amounts paid by  
6 them, if the payments to hospitals required under Section  
7 5A-12.4 are not eligible for federal matching funds under Title  
8 XIX of the Social Security Act.

9           (d) The assessments imposed by Section 5A-2 shall not take  
10 effect or shall cease to be imposed, the Department's  
11 obligation to make payments shall immediately cease, and any  
12 moneys remaining in the Fund shall be refunded to hospital  
13 providers in proportion to the amounts paid by them, if:

14           (1) for State fiscal years 2013 through 2020 ~~2018~~, the  
15 Department reduces any payment rates to hospitals as in  
16 effect on May 1, 2012, or alters any payment methodology as  
17 in effect on May 1, 2012, that has the effect of reducing  
18 payment rates to hospitals, except for any changes  
19 affecting hospitals authorized in Public Act 97-689 and any  
20 changes authorized by Section 14-12 of this Code, and  
21 except for any changes authorized under Section 5A-15, and  
22 except for any changes authorized under Section 5-5b.1;

23           (2) for State fiscal years 2013 through 2020 ~~2018~~, the  
24 Department reduces any supplemental payments made to  
25 hospitals below the amounts paid for services provided in  
26 State fiscal year 2011 as implemented by administrative



1 rules adopted and in effect on or prior to June 30, 2011,  
2 except for any changes affecting hospitals authorized in  
3 Public Act 97-689 and any changes authorized by Section  
4 14-12 of this Code, and except for any changes authorized  
5 under Section 5A-15, and except for any changes authorized  
6 under Section 5-5b.1; or

7 (3) for State fiscal years 2015 through 2020 ~~2018~~, the  
8 Department reduces the overall effective rate of  
9 reimbursement to hospitals below the level authorized  
10 under Section 14-12 of this Code, except for any changes  
11 under Section 14-12 or Section 5A-15 of this Code, and  
12 except for any changes authorized under Section 5-5b.1.

13 (Source: P.A. 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 99-2,  
14 eff. 3-26-15.)

15 (305 ILCS 5/5A-12.5)

16 Sec. 5A-12.5. Affordable Care Act adults; hospital access  
17 payments.

18 (a) The Department shall, subject to federal approval,  
19 mirror the Medical Assistance hospital reimbursement  
20 methodology for Affordable Care Act adults who are enrolled  
21 under a fee-for-service or capitated managed care program,  
22 including hospital access payments as defined in Section  
23 5A-12.2 of this Article and hospital access improvement  
24 payments as defined in Section 5A-12.4 of this Article, in  
25 compliance with the equivalent rate provisions of the

1 Affordable Care Act.

2 (b) If the fee-for-service payments authorized under this  
3 Section are deemed to be increases to payments for a prior  
4 period, the Department shall seek federal approval to issue  
5 such increases for the payments made through the period ending  
6 on June 30, 2020 ~~2018~~, even if such increases are paid out  
7 during an extended payment period beyond such date. Payment of  
8 such increases beyond such date is subject to federal approval.

9 (c) As used in this Section, "Affordable Care Act" is the  
10 collective term for the Patient Protection and Affordable Care  
11 Act (Pub. L. 111-148) and the Health Care and Education  
12 Reconciliation Act of 2010 (Pub. L. 111-152).

13 (Source: P.A. 98-651, eff. 6-16-14; 99-516, eff. 6-30-16.)

14 (305 ILCS 5/5A-14)

15 Sec. 5A-14. Repeal of assessments and disbursements.

16 (a) Section 5A-2 is repealed on July 1, 2020 ~~2018~~.

17 (b) Section 5A-12 is repealed on July 1, 2005.

18 (c) Section 5A-12.1 is repealed on July 1, 2008.

19 (d) Section 5A-12.2 and Section 5A-12.4 are repealed on  
20 July 1, 2020 ~~2018~~.

21 (e) Section 5A-12.3 is repealed on July 1, 2011.

22 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;  
23 98-651, eff. 6-16-14.)

24 (305 ILCS 5/12-4.105)

1           Sec. 12-4.105. Human poison control center; payment  
2 program. Subject to funding availability resulting from  
3 transfers made from the Hospital Provider Fund to the  
4 Healthcare Provider Relief Fund as authorized under this Code,  
5 for State fiscal year 2017 and State fiscal year 2020 ~~2018~~, the  
6 Department of Healthcare and Family Services shall pay to the  
7 human poison control center designated under the Poison Control  
8 System Act an amount of not less than \$3,000,000 for each of  
9 those State fiscal years that the human poison control center  
10 is in operation.

11         (Source: P.A. 99-516, eff. 6-30-16.)

12           (305 ILCS 5/14-12)

13           Sec. 14-12. Hospital rate reform payment system. The  
14 hospital payment system pursuant to Section 14-11 of this  
15 Article shall be as follows:

16           (a) Inpatient hospital services. Effective for discharges  
17 on and after July 1, 2014, reimbursement for inpatient general  
18 acute care services shall utilize the All Patient Refined  
19 Diagnosis Related Grouping (APR-DRG) software, version 30,  
20 distributed by 3M<sup>TM</sup> Health Information System.

21           (1) The Department shall establish Medicaid weighting  
22 factors to be used in the reimbursement system established  
23 under this subsection. Initial weighting factors shall be  
24 the weighting factors as published by 3M Health Information  
25 System, associated with Version 30.0 adjusted for the

1 Illinois experience.

2 (2) The Department shall establish a  
3 statewide-standardized amount to be used in the inpatient  
4 reimbursement system. The Department shall publish these  
5 amounts on its website no later than 10 calendar days prior  
6 to their effective date.

7 (3) In addition to the statewide-standardized amount,  
8 the Department shall develop adjusters to adjust the rate  
9 of reimbursement for critical Medicaid providers or  
10 services for trauma, transplantation services, perinatal  
11 care, and Graduate Medical Education (GME).

12 (4) The Department shall develop add-on payments to  
13 account for exceptionally costly inpatient stays,  
14 consistent with Medicare outlier principles. Outlier fixed  
15 loss thresholds may be updated to control for excessive  
16 growth in outlier payments no more frequently than on an  
17 annual basis, but at least triennially. Upon updating the  
18 fixed loss thresholds, the Department shall be required to  
19 update base rates within 12 months.

20 (5) The Department shall define those hospitals or  
21 distinct parts of hospitals that shall be exempt from the  
22 APR-DRG reimbursement system established under this  
23 Section. The Department shall publish these hospitals'  
24 inpatient rates on its website no later than 10 calendar  
25 days prior to their effective date.

26 (6) Beginning July 1, 2014 and ending on June 30, 2018,

1 in addition to the statewide-standardized amount, the  
2 Department shall develop an adjustor to adjust the rate of  
3 reimbursement for safety-net hospitals defined in Section  
4 5-5e.1 of this Code excluding pediatric hospitals.

5 (7) Beginning July 1, 2014 and ending on June 30, 2018,  
6 in addition to the statewide-standardized amount, the  
7 Department shall develop an adjustor to adjust the rate of  
8 reimbursement for Illinois freestanding inpatient  
9 psychiatric hospitals that are not designated as  
10 children's hospitals by the Department but are primarily  
11 treating patients under the age of 21.

12 (b) Outpatient hospital services. Effective for dates of  
13 service on and after July 1, 2014, reimbursement for outpatient  
14 services shall utilize the Enhanced Ambulatory Procedure  
15 Grouping (E-APG) software, version 3.7 distributed by 3M<sup>TM</sup>  
16 Health Information System.

17 (1) The Department shall establish Medicaid weighting  
18 factors to be used in the reimbursement system established  
19 under this subsection. The initial weighting factors shall  
20 be the weighting factors as published by 3M Health  
21 Information System, associated with Version 3.7.

22 (2) The Department shall establish service specific  
23 statewide-standardized amounts to be used in the  
24 reimbursement system.

25 (A) The initial statewide standardized amounts,  
26 with the labor portion adjusted by the Calendar Year

1           2013 Medicare Outpatient Prospective Payment System  
2           wage index with reclassifications, shall be published  
3           by the Department on its website no later than 10  
4           calendar days prior to their effective date.

5           (B) The Department shall establish adjustments to  
6           the statewide-standardized amounts for each Critical  
7           Access Hospital, as designated by the Department of  
8           Public Health in accordance with 42 CFR 485, Subpart F.  
9           The EAPG standardized amounts are determined  
10          separately for each critical access hospital such that  
11          simulated EAPG payments using outpatient base period  
12          paid claim data plus payments under Section 5A-12.4 of  
13          this Code net of the associated tax costs are equal to  
14          the estimated costs of outpatient base period claims  
15          data with a rate year cost inflation factor applied.

16          (3) In addition to the statewide-standardized amounts,  
17          the Department shall develop adjusters to adjust the rate  
18          of reimbursement for critical Medicaid hospital outpatient  
19          providers or services, including outpatient high volume or  
20          safety-net hospitals.

21          (c) In consultation with the hospital community, the  
22          Department is authorized to replace 89 Ill. Admin. Code 152.150  
23          as published in 38 Ill. Reg. 4980 through 4986 within 12 months  
24          of the effective date of this amendatory Act of the 98th  
25          General Assembly. If the Department does not replace these  
26          rules within 12 months of the effective date of this amendatory

1 Act of the 98th General Assembly, the rules in effect for  
2 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall  
3 remain in effect until modified by rule by the Department.  
4 Nothing in this subsection shall be construed to mandate that  
5 the Department file a replacement rule.

6 (d) Transition period. There shall be a transition period  
7 to the reimbursement systems authorized under this Section that  
8 shall begin on the effective date of these systems and continue  
9 until June 30, 2020 ~~2018~~, unless extended by rule by the  
10 Department. To help provide an orderly and predictable  
11 transition to the new reimbursement systems and to preserve and  
12 enhance access to the hospital services during this transition,  
13 the Department shall allocate a transitional hospital access  
14 pool of at least \$290,000,000 annually so that transitional  
15 hospital access payments are made to hospitals.

16 (1) After the transition period, the Department may  
17 begin incorporating the transitional hospital access pool  
18 into the base rate structure.

19 (2) After the transition period, if the Department  
20 reduces payments from the transitional hospital access  
21 pool, it shall increase base rates, develop new adjustors,  
22 adjust current adjustors, develop new hospital access  
23 payments based on updated information, or any combination  
24 thereof by an amount equal to the decreases proposed in the  
25 transitional hospital access pool payments, ensuring that  
26 the entire transitional hospital access pool amount shall

1 continue to be used for hospital payments.

2 (e) Beginning 36 months after initial implementation, the  
3 Department shall update the reimbursement components in  
4 subsections (a) and (b), including standardized amounts and  
5 weighting factors, and at least triennially and no more  
6 frequently than annually thereafter. The Department shall  
7 publish these updates on its website no later than 30 calendar  
8 days prior to their effective date.

9 (f) Continuation of supplemental payments. Any  
10 supplemental payments authorized under Illinois Administrative  
11 Code 148 effective January 1, 2014 and that continue during the  
12 period of July 1, 2014 through December 31, 2014 shall remain  
13 in effect as long as the assessment imposed by Section 5A-2 is  
14 in effect.

15 (g) Notwithstanding subsections (a) through (f) of this  
16 Section and notwithstanding the changes authorized under  
17 Section 5-5b.1, any updates to the system shall not result in  
18 any diminishment of the overall effective rates of  
19 reimbursement as of the implementation date of the new system  
20 (July 1, 2014). These updates shall not preclude variations in  
21 any individual component of the system or hospital rate  
22 variations. Nothing in this Section shall prohibit the  
23 Department from increasing the rates of reimbursement or  
24 developing payments to ensure access to hospital services.  
25 Nothing in this Section shall be construed to guarantee a  
26 minimum amount of spending in the aggregate or per hospital as



1 spending may be impacted by factors including but not limited  
2 to the number of individuals in the medical assistance program  
3 and the severity of illness of the individuals.

4 (h) The Department shall have the authority to modify by  
5 rulemaking any changes to the rates or methodologies in this  
6 Section as required by the federal government to obtain federal  
7 financial participation for expenditures made under this  
8 Section.

9 (i) Except for subsections (g) and (h) of this Section, the  
10 Department shall, pursuant to subsection (c) of Section 5-40 of  
11 the Illinois Administrative Procedure Act, provide for  
12 presentation at the June 2014 hearing of the Joint Committee on  
13 Administrative Rules (JCAR) additional written notice to JCAR  
14 of the following rules in order to commence the second notice  
15 period for the following rules: rules published in the Illinois  
16 Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559  
17 (Medical Payment), 4628 (Specialized Health Care Delivery  
18 Systems), 4640 (Hospital Services), 4932 (Diagnostic Related  
19 Grouping (DRG) Prospective Payment System (PPS)), and 4977  
20 (Hospital Reimbursement Changes), and published in the  
21 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499  
22 (Specialized Health Care Delivery Systems) and 6505 (Hospital  
23 Services).  
24 (Source: P.A. 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

25 Section 99. Effective date. This Act takes effect July 1,  
26 2017.