



97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB5746

Introduced 2/16/2012, by Rep. Camille Y Lilly

SYNOPSIS AS INTRODUCED:

See Index

Amend the Hospital Provider Funding Article of the Illinois Public Aid Code. Imposes specific assessments on outpatient services for State fiscal years 2012 through 2014. Provides that no installment payment of an assessment shall be due and payable until after: (i) the Department of Healthcare and Family Services notifies the hospital provider, in writing, that certain payment methodologies to hospitals required under the Article have been approved by the Centers for Medicare and Medicaid Services and a specified federal waiver has been granted by the Centers for Medicare and Medicaid Services; and (ii) the Comptroller has issued the payments required under the Article. Requires certain money transfers from the Hospital Provider Fund for State fiscal years 2012, 2013, and 2014. Provides that the new assessments shall not take effect or shall cease to be imposed if certain criteria are met. Contains provisions concerning hospital access improvement payments on or after January 1, 2012; magnet and perinatal hospital adjustments; trauma level II adjustments; dual eligible adjustments; medicaid volume adjustments; outpatient service adjustments; care coordination adjustments; specialty hospital adjustments; and physician supplemental adjustments. Defines terms. Makes other changes. Effective immediately.

LRB097 18814 KTG 65663 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 5A-1, 5A-2, 5A-4, 5A-5, 5A-8, 5A-10, 5A-13,
6 and 5A-14 and by adding Section 5A-12.4 as follows:

7 (305 ILCS 5/5A-1) (from Ch. 23, par. 5A-1)

8 Sec. 5A-1. Definitions. As used in this Article, unless
9 the context requires otherwise:

10 "Adjusted gross hospital revenue" shall be determined
11 separately for inpatient and outpatient services for each
12 hospital conducted, operated or maintained by a hospital
13 provider, and means the hospital provider's total gross
14 revenues less: (i) gross revenue attributable to non-hospital
15 based services including home dialysis services, durable
16 medical equipment, ambulance services, outpatient clinics and
17 any other non-hospital based services as determined by the
18 Illinois Department by rule; and (ii) gross revenues
19 attributable to the routine services provided to persons
20 receiving skilled or intermediate long-term care services
21 within the meaning of Title XVIII or XIX of the Social Security
22 Act; and (iii) Medicare gross revenue (excluding the Medicare
23 gross revenue attributable to clauses (i) and (ii) of this

1 paragraph and the Medicare gross revenue attributable to the
2 routine services provided to patients in a psychiatric
3 hospital, a rehabilitation hospital, a distinct part
4 psychiatric unit, a distinct part rehabilitation unit, or swing
5 beds). Adjusted gross hospital revenue shall be determined
6 using the most recent data available from each hospital's 2003
7 Medicare cost report as contained in the Healthcare Cost Report
8 Information System file, for the quarter ending on December 31,
9 2004, without regard to any subsequent adjustments or changes
10 to such data. If a hospital's 2003 Medicare cost report is not
11 contained in the Healthcare Cost Report Information System, the
12 hospital provider shall furnish such cost report or the data
13 necessary to determine its adjusted gross hospital revenue as
14 required by rule by the Illinois Department.

15 "Fund" means the Hospital Provider Fund.

16 "Hospital" means an institution, place, building, or
17 agency located in this State that is subject to licensure by
18 the Illinois Department of Public Health under the Hospital
19 Licensing Act, whether public or private and whether organized
20 for profit or not-for-profit.

21 "Hospital provider" means a person licensed by the
22 Department of Public Health to conduct, operate, or maintain a
23 hospital, regardless of whether the person is a Medicaid
24 provider. For purposes of this paragraph, "person" means any
25 political subdivision of the State, municipal corporation,
26 individual, firm, partnership, corporation, company, limited

1 liability company, association, joint stock association, or
2 trust, or a receiver, executor, trustee, guardian, or other
3 representative appointed by order of any court.

4 "Medicare bed days" means, for each hospital, the sum of
5 the number of days that each bed was occupied by a patient who
6 was covered by Title XVIII of the Social Security Act,
7 excluding days attributable to the routine services provided to
8 persons receiving skilled or intermediate long term care
9 services. Medicare bed days shall be computed separately for
10 each hospital operated or maintained by a hospital provider.

11 "Occupied bed days" means the sum of the number of days
12 that each bed was occupied by a patient for all beds, excluding
13 days attributable to the routine services provided to persons
14 receiving skilled or intermediate long term care services.
15 Occupied bed days shall be computed separately for each
16 hospital operated or maintained by a hospital provider.

17 "Outpatient gross revenue" means, for each hospital, its
18 total gross charges attributed to outpatient services as
19 reported on the Medicare cost report at Worksheet C, Part I,
20 Column 7, line 101, less the sum of lines 45, 60, 63, 64, 65,
21 66, 67, and 68 (and any subsets of those lines).

22 "Proration factor" means a fraction, the numerator of which
23 is 53 and the denominator of which is 365.

24 (Source: P.A. 94-242, eff. 7-18-05; 95-859, eff. 8-19-08.)

25 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

1 (Section scheduled to be repealed on July 1, 2014)

2 Sec. 5A-2. Assessment.

3 (a) Subject to Sections 5A-3 and 5A-10, an annual
4 assessment on inpatient services is imposed on each hospital
5 provider in an amount equal to the hospital's occupied bed days
6 multiplied by \$84.19 multiplied by the proration factor for
7 State fiscal year 2004 and the hospital's occupied bed days
8 multiplied by \$84.19 for State fiscal year 2005.

9 For State fiscal years 2004 and 2005, the Department of
10 Healthcare and Family Services shall use the number of occupied
11 bed days as reported by each hospital on the Annual Survey of
12 Hospitals conducted by the Department of Public Health to
13 calculate the hospital's annual assessment. If the sum of a
14 hospital's occupied bed days is not reported on the Annual
15 Survey of Hospitals or if there are data errors in the reported
16 sum of a hospital's occupied bed days as determined by the
17 Department of Healthcare and Family Services (formerly
18 Department of Public Aid), then the Department of Healthcare
19 and Family Services may obtain the sum of occupied bed days
20 from any source available, including, but not limited to,
21 records maintained by the hospital provider, which may be
22 inspected at all times during business hours of the day by the
23 Department of Healthcare and Family Services or its duly
24 authorized agents and employees.

25 Subject to Sections 5A-3 and 5A-10, for the privilege of
26 engaging in the occupation of hospital provider, beginning

1 August 1, 2005, an annual assessment is imposed on each
2 hospital provider for State fiscal years 2006, 2007, and 2008,
3 in an amount equal to 2.5835% of the hospital provider's
4 adjusted gross hospital revenue for inpatient services and
5 2.5835% of the hospital provider's adjusted gross hospital
6 revenue for outpatient services. If the hospital provider's
7 adjusted gross hospital revenue is not available, then the
8 Illinois Department may obtain the hospital provider's
9 adjusted gross hospital revenue from any source available,
10 including, but not limited to, records maintained by the
11 hospital provider, which may be inspected at all times during
12 business hours of the day by the Illinois Department or its
13 duly authorized agents and employees.

14 Subject to Sections 5A-3 and 5A-10, for State fiscal years
15 2009 through 2014, an annual assessment on inpatient services
16 is imposed on each hospital provider in an amount equal to
17 \$218.38 multiplied by the difference of the hospital's occupied
18 bed days less the hospital's Medicare bed days.

19 For State fiscal years 2009 through 2014, a hospital's
20 occupied bed days and Medicare bed days shall be determined
21 using the most recent data available from each hospital's 2005
22 Medicare cost report as contained in the Healthcare Cost Report
23 Information System file, for the quarter ending on December 31,
24 2006, without regard to any subsequent adjustments or changes
25 to such data. If a hospital's 2005 Medicare cost report is not
26 contained in the Healthcare Cost Report Information System,

1 then the Illinois Department may obtain the hospital provider's
2 occupied bed days and Medicare bed days from any source
3 available, including, but not limited to, records maintained by
4 the hospital provider, which may be inspected at all times
5 during business hours of the day by the Illinois Department or
6 its duly authorized agents and employees.

7 (b) (Blank).

8 (b-5) Subject to Sections 5A-3 and 5A-10, for State fiscal
9 years 2012 through 2014, an annual assessment on outpatient
10 services is imposed on each hospital provider in an amount
11 equal to .007236 multiplied by the hospital's outpatient gross
12 revenue. For State fiscal year 2012, the amount of the
13 assessment shall be prorated based on the portion of the fiscal
14 year for which it and the payments authorized under Section
15 5A-12.4 are in effect.

16 For State fiscal years 2012 through 2014, a hospital's
17 outpatient gross revenue shall be determined using the most
18 recent data available from each hospital's 2009 Medicare cost
19 report as contained in the Healthcare Cost Report Information
20 System file, for the quarter ending on June 30, 2011, without
21 regard to any subsequent adjustments or changes to such data.
22 If a hospital's 2009 Medicare cost report is not contained in
23 the Healthcare Cost Report Information System, then the
24 Department may obtain the hospital provider's outpatient gross
25 revenue from any source available, including, but not limited
26 to, records maintained by the hospital provider, which may be

1 inspected at all times during business hours of the day by the
2 Department or its duly authorized agents and employees.

3 (c) (Blank).

4 (d) Notwithstanding any of the other provisions of this
5 Section, the Department is authorized, during this 94th General
6 Assembly, to adopt rules to reduce the rate of any annual
7 assessment imposed under this Section, as authorized by Section
8 5-46.2 of the Illinois Administrative Procedure Act.

9 (e) Notwithstanding any other provision of this Section,
10 any plan providing for an assessment on a hospital provider as
11 a permissible tax under Title XIX of the federal Social
12 Security Act and Medicaid-eligible payments to hospital
13 providers from the revenues derived from that assessment shall
14 be reviewed by the Illinois Department of Healthcare and Family
15 Services, as the Single State Medicaid Agency required by
16 federal law, to determine whether those assessments and
17 hospital provider payments meet federal Medicaid standards. If
18 the Department determines that the elements of the plan may
19 meet federal Medicaid standards and a related State Medicaid
20 Plan Amendment is prepared in a manner and form suitable for
21 submission, that State Plan Amendment shall be submitted in a
22 timely manner for review by the Centers for Medicare and
23 Medicaid Services of the United States Department of Health and
24 Human Services and subject to approval by the Centers for
25 Medicare and Medicaid Services of the United States Department
26 of Health and Human Services. No such plan shall become

1 effective without approval by the Illinois General Assembly by
2 the enactment into law of related legislation. Notwithstanding
3 any other provision of this Section, the Department is
4 authorized to adopt rules to reduce the rate of any annual
5 assessment imposed under this Section. Any such rules may be
6 adopted by the Department under Section 5-50 of the Illinois
7 Administrative Procedure Act.

8 (Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

9 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

11 (a) The annual assessment imposed by Section 5A-2 for State
12 fiscal year 2004 shall be due and payable on June 18 of the
13 year. The assessment imposed by Section 5A-2 for State fiscal
14 year 2005 shall be due and payable in quarterly installments,
15 each equalling one-fourth of the assessment for the year, on
16 July 19, October 19, January 18, and April 19 of the year. The
17 assessment imposed by Section 5A-2 for State fiscal years 2006
18 through 2008 shall be due and payable in quarterly
19 installments, each equaling one-fourth of the assessment for
20 the year, on the fourteenth State business day of September,
21 December, March, and May. Except as provided in subsection
22 (a-5) of this Section, the assessment imposed by Section 5A-2
23 for State fiscal year 2009 and each subsequent State fiscal
24 year shall be due and payable in monthly installments, each
25 equaling one-twelfth of the assessment for the year, on the

1 fourteenth State business day of each month. No installment
2 payment of an assessment imposed by Section 5A-2 shall be due
3 and payable, however, until after: (i) the Department notifies
4 the hospital provider, in writing, that the payment
5 methodologies to hospitals required under Section 5A-12,
6 Section 5A-12.1, or Section 5A-12.2, whichever is applicable
7 for that fiscal year, have been approved by the Centers for
8 Medicare and Medicaid Services of the U.S. Department of Health
9 and Human Services and the waiver under 42 CFR 433.68 for the
10 assessment imposed by Section 5A-2, if necessary, has been
11 granted by the Centers for Medicare and Medicaid Services of
12 the U.S. Department of Health and Human Services; and (ii) the
13 Comptroller has issued the payments required under Section
14 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is
15 applicable for that fiscal year. Upon notification to the
16 Department of approval of the payment methodologies required
17 under Section 5A-12, Section 5A-12.1, or Section 5A-12.2,
18 whichever is applicable for that fiscal year, and the waiver
19 granted under 42 CFR 433.68, all installments otherwise due
20 under Section 5A-2 prior to the date of notification shall be
21 due and payable to the Department upon written direction from
22 the Department and issuance by the Comptroller of the payments
23 required under Section 5A-12.1 or Section 5A-12.2, whichever is
24 applicable for that fiscal year.

25 Except as provided in subsection (a-5) of this Section, the
26 assessment imposed by subsection (b-5) of Section 5A-2 for

1 State fiscal year 2012 and each subsequent State fiscal year
2 shall be due and payable in monthly installments, each equaling
3 one-twelfth of the assessment for the year, on the 14th State
4 business day of each month. No installment payment of an
5 assessment imposed by subsection (b-5) of Section 5A-2 shall be
6 due and payable, however, until after: (i) the Department
7 notifies the hospital provider, in writing, that the payment
8 methodologies to hospitals required under Section 5A-12.4,
9 have been approved by the Centers for Medicare and Medicaid
10 Services of the U.S. Department of Health and Human Services,
11 and the waiver under 42 CFR 433.68 for the assessment imposed
12 by subsection (b-5) of Section 5A-2, if necessary, has been
13 granted by the Centers for Medicare and Medicaid Services of
14 the U.S. Department of Health and Human Services; and (ii) the
15 Comptroller has issued the payments required under Section
16 5A-12.4. Upon notification to the Department of approval of the
17 payment methodologies required under Section 5A-12.4 and the
18 waiver granted under 42 CFR 433.68, if necessary, all
19 installments otherwise due under subsection (b-5) of Section
20 5A-2 prior to the date of notification shall be due and payable
21 to the Department upon written direction from the Department
22 and issuance by the Comptroller of the payments required under
23 Section 5A-12.4.

24 (a-5) The Illinois Department may, ~~for the purpose of~~
25 ~~maximizing federal revenue,~~ accelerate the schedule upon which
26 assessment installments are due and payable by hospitals with a

1 payment ratio greater than or equal to one. Such acceleration
2 of due dates for payment of the assessment may be made only in
3 conjunction with a corresponding acceleration in access
4 payments identified in Section 5A-12.2 or Section 5A-12.4 to
5 the same hospitals. For the purposes of this subsection (a-5),
6 a hospital's payment ratio is defined as the quotient obtained
7 by dividing the total payments for the State fiscal year, as
8 authorized under Section 5A-12.2 or Section 5A-12.4, by the
9 total assessment for the State fiscal year imposed under
10 Section 5A-2 or subsection (b-5) of Section 5A-2.

11 (b) The Illinois Department is authorized to establish
12 delayed payment schedules for hospital providers that are
13 unable to make installment payments when due under this Section
14 due to financial difficulties, as determined by the Illinois
15 Department.

16 (c) If a hospital provider fails to pay the full amount of
17 an installment when due (including any extensions granted under
18 subsection (b)), there shall, unless waived by the Illinois
19 Department for reasonable cause, be added to the assessment
20 imposed by Section 5A-2 a penalty assessment equal to the
21 lesser of (i) 5% of the amount of the installment not paid on
22 or before the due date plus 5% of the portion thereof remaining
23 unpaid on the last day of each 30-day period thereafter or (ii)
24 100% of the installment amount not paid on or before the due
25 date. For purposes of this subsection, payments will be
26 credited first to unpaid installment amounts (rather than to

1 penalty or interest), beginning with the most delinquent
2 installments.

3 (d) Any assessment amount that is due and payable to the
4 Illinois Department more frequently than once per calendar
5 quarter shall be remitted to the Illinois Department by the
6 hospital provider by means of electronic funds transfer. The
7 Illinois Department may provide for remittance by other means
8 if (i) the amount due is less than \$10,000 or (ii) electronic
9 funds transfer is unavailable for this purpose.

10 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
11 96-821, eff. 11-20-09.)

12 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)

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

14 (a) The Department of Healthcare and Family Services shall
15 send a notice of assessment to every hospital provider subject
16 to assessment under this Article. The notice of assessment
17 shall notify the hospital of its assessment and shall be sent
18 after receipt by the Department of notification from the
19 Centers for Medicare and Medicaid Services of the U.S.
20 Department of Health and Human Services that the payment
21 methodologies required under Section 5A-12, Section 5A-12.1,
22 or Section 5A-12.2, or Section 5A-12.4, whichever is applicable
23 for that fiscal year, and, if necessary, the waiver granted
24 under 42 CFR 433.68 have been approved. The notice shall be on
25 a form prepared by the Illinois Department and shall state the

1 following:

2 (1) The name of the hospital provider.

3 (2) The address of the hospital provider's principal
4 place of business from which the provider engages in the
5 occupation of hospital provider in this State, and the name
6 and address of each hospital operated, conducted, or
7 maintained by the provider in this State.

8 (3) The occupied bed days, occupied bed days less
9 Medicare days, ~~or~~ adjusted gross hospital revenue, or
10 outpatient gross revenue of the hospital provider
11 (whichever is applicable), the amount of assessment
12 imposed under Section 5A-2 for the State fiscal year for
13 which the notice is sent, and the amount of each
14 installment to be paid during the State fiscal year.

15 (4) (Blank).

16 (5) Other reasonable information as determined by the
17 Illinois Department.

18 (b) If a hospital provider conducts, operates, or maintains
19 more than one hospital licensed by the Illinois Department of
20 Public Health, the provider shall pay the assessment for each
21 hospital separately.

22 (c) Notwithstanding any other provision in this Article, in
23 the case of a person who ceases to conduct, operate, or
24 maintain a hospital in respect of which the person is subject
25 to assessment under this Article as a hospital provider, the
26 assessment for the State fiscal year in which the cessation

1 occurs shall be adjusted by multiplying the assessment computed
2 under Section 5A-2 by a fraction, the numerator of which is the
3 number of days in the year during which the provider conducts,
4 operates, or maintains the hospital and the denominator of
5 which is 365. Immediately upon ceasing to conduct, operate, or
6 maintain a hospital, the person shall pay the assessment for
7 the year as so adjusted (to the extent not previously paid).

8 (d) Notwithstanding any other provision in this Article, a
9 provider who commences conducting, operating, or maintaining a
10 hospital, upon notice by the Illinois Department, shall pay the
11 assessment computed under Section 5A-2 and subsection (e) in
12 installments on the due dates stated in the notice and on the
13 regular installment due dates for the State fiscal year
14 occurring after the due dates of the initial notice.

15 (e) Notwithstanding any other provision in this Article,
16 for State fiscal years 2004 and 2005, in the case of a hospital
17 provider that did not conduct, operate, or maintain a hospital
18 throughout calendar year 2001, the assessment for that State
19 fiscal year shall be computed on the basis of hypothetical
20 occupied bed days for the full calendar year as determined by
21 the Illinois Department. Notwithstanding any other provision
22 in this Article, for State fiscal years 2006 through 2008, in
23 the case of a hospital provider that did not conduct, operate,
24 or maintain a hospital in 2003, the assessment for that State
25 fiscal year shall be computed on the basis of hypothetical
26 adjusted gross hospital revenue for the hospital's first full

1 fiscal year as determined by the Illinois Department (which may
2 be based on annualization of the provider's actual revenues for
3 a portion of the year, or revenues of a comparable hospital for
4 the year, including revenues realized by a prior provider of
5 the same hospital during the year). Notwithstanding any other
6 provision in this Article, for State fiscal years 2009 through
7 2014, in the case of a hospital provider that did not conduct,
8 operate, or maintain a hospital in 2009, the assessment for
9 that State fiscal year shall be computed on the basis of
10 hypothetical occupied bed days for the full calendar year as
11 determined by the Illinois Department. Notwithstanding any
12 other provision in this Article, for State fiscal years 2012
13 through 2014, in the case of a hospital provider that did not
14 conduct, operate, or maintain a hospital in 2009, the
15 assessment under subsection (b-5) of Section 5A-2 for that
16 State fiscal year shall be computed on the basis of
17 hypothetical gross outpatient revenue for the full calendar
18 year as determined by the Illinois Department.

19 (f) Every hospital provider subject to assessment under
20 this Article shall keep sufficient records to permit the
21 determination of adjusted gross hospital revenue for the
22 hospital's fiscal year. All such records shall be kept in the
23 English language and shall, at all times during regular
24 business hours of the day, be subject to inspection by the
25 Illinois Department or its duly authorized agents and
26 employees.

1 (g) The Illinois Department may, by rule, provide a
2 hospital provider a reasonable opportunity to request a
3 clarification or correction of any clerical or computational
4 errors contained in the calculation of its assessment, but such
5 corrections shall not extend to updating the cost report
6 information used to calculate the assessment.

7 (h) (Blank).

8 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
9 96-1530, eff. 2-16-11.)

10 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

11 Sec. 5A-8. Hospital Provider Fund.

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

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

20 (1) For making payments to hospitals as required under
21 Articles V, V-A, VI, and XIV of this Code, under the
22 Children's Health Insurance Program Act, under the
23 Covering ALL KIDS Health Insurance Act, and under the
24 Senior Citizens and Disabled Persons Property Tax Relief
25 and Pharmaceutical Assistance Act.

1 (2) For the reimbursement of moneys collected by the
2 Illinois Department from hospitals or hospital providers
3 through error or mistake in performing the activities
4 authorized under this Article and Article V of this Code.

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

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

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

17 (6) For making transfers to any other fund in the State
18 treasury, but transfers made under this paragraph (6) shall
19 not exceed the amount transferred previously from that
20 other fund into the Hospital Provider Fund.

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

25 (7) For State fiscal years 2004 and 2005 for making
26 transfers to the Health and Human Services Medicaid Trust

1 Fund, including 20% of the moneys received from hospital
 2 providers under Section 5A-4 and transferred into the
 3 Hospital Provider Fund under Section 5A-6. For State fiscal
 4 year 2006 for making transfers to the Health and Human
 5 Services Medicaid Trust Fund of up to \$130,000,000 per year
 6 of the moneys received from hospital providers under
 7 Section 5A-4 and transferred into the Hospital Provider
 8 Fund under Section 5A-6. Transfers under this paragraph
 9 shall be made within 7 days after the payments have been
 10 received pursuant to the schedule of payments provided in
 11 subsection (a) of Section 5A-4.

12 (7.5) For State fiscal year 2007 for making transfers
 13 of the moneys received from hospital providers under
 14 Section 5A-4 and transferred into the Hospital Provider
 15 Fund under Section 5A-6 to the designated funds not
 16 exceeding the following amounts in that State fiscal year:

17 Health and Human Services

18 Medicaid Trust Fund	\$20,000,000
19 Long-Term Care Provider Fund	\$30,000,000
20 General Revenue Fund	\$80,000,000.

21 Transfers under this paragraph shall be made within 7
 22 days after the payments have been received pursuant to the
 23 schedule of payments provided in subsection (a) of Section
 24 5A-4.

25 (7.8) For State fiscal year 2008, for making transfers
 26 of the moneys received from hospital providers under

1 Section 5A-4 and transferred into the Hospital Provider
 2 Fund under Section 5A-6 to the designated funds not
 3 exceeding the following amounts in that State fiscal year:

4 Health and Human Services

5 Medicaid Trust Fund	\$40,000,000
6 Long-Term Care Provider Fund	\$60,000,000
7 General Revenue Fund	\$160,000,000.

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

12 (7.9) For State fiscal years 2009 through 2014, for
 13 making transfers of the moneys 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 and Human Services

19 Medicaid Trust Fund	\$20,000,000
20 Long Term Care Provider Fund	\$30,000,000
21 General Revenue Fund	\$80,000,000.

22 Except as provided under this paragraph, transfers
 23 under this paragraph shall be made within 7 business days
 24 after the payments have been received pursuant to the
 25 schedule of payments provided in subsection (a) of Section
 26 5A-4. For State fiscal year 2009, transfers to the General

1 Revenue Fund under this paragraph shall be made on or
2 before June 30, 2009, as sufficient funds become available
3 in the Hospital Provider Fund to both make the transfers
4 and continue hospital payments.

5 (7.10) For State fiscal year 2012, for making transfers
6 of the moneys resulting from the assessment under
7 subsection (b-5) of Section 5A-2 and received from hospital
8 providers under Section 5A-4 and transferred into the
9 Hospital Provider Fund under Section 5A-6 to the designated
10 funds not exceeding the following amounts in that State
11 fiscal year:

12 Health Care Provider Relief Fund \$10,000,000

13 Transfers under this paragraph shall be made within 7
14 days after the payments have been received pursuant to the
15 schedule of payments provided in subsection (a) of Section
16 5A-4.

17 (7.11) For State fiscal years 2013 and 2014, for making
18 transfers of the moneys resulting from the assessment under
19 subsection (b-5) of Section 5A-2 and received from hospital
20 providers under Section 5A-4 and transferred into the
21 Hospital Provider Fund under Section 5A-6 to the designated
22 funds not exceeding the following amounts in that State
23 fiscal year:

24 Health Care Provider Relief Fund \$20,000,000

25 Transfers under this paragraph shall be made within 7
26 days after the payments have been received pursuant to the

1 schedule of payments provided in subsection (a) of Section
2 5A-4.

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

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

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

11 (1) All moneys collected or received by the Illinois
12 Department from the hospital provider assessment imposed
13 by this Article.

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

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

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. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3,
26 eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09;

1 96-1530, eff. 2-16-11.)

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 not take effect or shall cease to be imposed, and
6 any moneys remaining in the Fund shall be refunded to hospital
7 providers in proportion to the amounts paid by them, if:

8 (1) The sum of the appropriations for State fiscal
9 years 2004 and 2005 from the General Revenue Fund for
10 hospital payments under the medical assistance program is
11 less than \$4,500,000,000 or the appropriation for each of
12 State fiscal years 2006, 2007 and 2008 from the General
13 Revenue Fund for hospital payments under the medical
14 assistance program is less than \$2,500,000,000 increased
15 annually to reflect any increase in the number of
16 recipients, or the annual appropriation for State fiscal
17 years 2009, 2010, 2011, 2013, and 2014, from the General
18 Revenue Fund combined with the Hospital Provider Fund as
19 authorized in Section 5A-8 for hospital payments under the
20 medical assistance program, is less than the amount
21 appropriated for State fiscal year 2009, adjusted annually
22 to reflect any change in the number of recipients,
23 excluding State fiscal year 2009 supplemental
24 appropriations made necessary by the enactment of the
25 American Recovery and Reinvestment Act of 2009; or

1 (2) For State fiscal years prior to State fiscal year
2 2009, the Department of Healthcare and Family Services
3 (formerly Department of Public Aid) makes changes in its
4 rules that reduce the hospital inpatient or outpatient
5 payment rates, including adjustment payment rates, in
6 effect on October 1, 2004, except for hospitals described
7 in subsection (b) of Section 5A-3 and except for changes in
8 the methodology for calculating outlier payments to
9 hospitals for exceptionally costly stays, so long as those
10 changes do not reduce aggregate expenditures below the
11 amount expended in State fiscal year 2005 for such
12 services; or

13 (2.1) For State fiscal years 2009 through 2014, the
14 Department of Healthcare and Family Services adopts any
15 administrative rule change to reduce payment rates or
16 alters any payment methodology that reduces any payment
17 rates made to operating hospitals under the approved Title
18 XIX or Title XXI State plan in effect January 1, 2008
19 except for:

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

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

24 (C) any changes proposed in State plan amendment
25 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
26 08-07; or

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;
6 provided that the Department shall be limited to one
7 such modification during the 36-month period after the
8 effective date of this amendatory Act of the 96th
9 General Assembly; or

10 (3) The payments to hospitals required under Section
11 5A-12 or Section 5A-12.2 are changed or are not eligible
12 for federal matching funds under Title XIX or XXI of the
13 Social Security Act.

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

24 (c) The assessments imposed by subsection (b-5) of Section
25 5A-2 shall not take effect or shall cease to be imposed, and
26 any moneys remaining in the Fund shall be refunded to hospital

1 providers in proportion to the amounts paid by them, if the
2 payments to hospitals required under Section 5A-12.4 are
3 changed, unless the change is pursuant to subsection (p) of
4 Section 5A-12.4 or are not eligible for federal matching funds
5 under Title XIX of the Social Security Act.

6 (d) The assessments imposed by Section 5A-2 shall not take
7 effect or shall cease to be imposed, and any moneys remaining
8 in the Fund shall be refunded to hospital providers in
9 proportion to the amounts paid by them, if:

10 (1) for State fiscal years 2012 through 2014, the
11 Department reduces any payment rates to hospitals as in
12 effect on November 1, 2011, or alters any payment
13 methodology as in effect on November 1, 2011, that has the
14 effect of reducing payment rates to hospitals; or

15 (2) for State fiscal years 2012 through 2014, the
16 Department reduces any supplemental payments made to
17 hospitals below the amounts paid for services provided in
18 State fiscal year 2011 as implemented by administrative
19 rules adopted and in effect on or prior to June 30, 2011.

20 (e) If the payments under Section 5A-12.4 are reduced
21 pursuant to subsection (p) of Section 5A-12.4, then the
22 assessment rate imposed under subsection (b-5) of Section 5A-2
23 shall be reduced such that the aggregate assessment is reduced
24 by 50% of the amount of any reduction in payments pursuant to
25 subsection (p) of Section 5A-12.4.

26 (Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72,

1 eff. 7-1-11; 97-74, eff. 6-30-11.)

2 (305 ILCS 5/5A-12.4 new)

3 Sec. 5A-12.4. Hospital access improvement payments on or
4 after January 1, 2012.

5 (a) Hospital access improvement payments. To preserve and
6 improve access to hospital services, for hospital and physician
7 services rendered on or after January 1, 2012, the Illinois
8 Department shall, except for hospitals described in subsection
9 (b) of Section 5A-3, make payments to hospitals as set forth in
10 this Section. These payments shall be paid in 12 equal
11 installments on or before the 7th State business day of each
12 month, except that no payment shall be due within 100 days
13 after the later of the date of notification of federal approval
14 of the payment methodologies required under this Section or any
15 waiver required under 42 CFR 433.68, at which time the sum of
16 amounts required under this Section prior to the date of
17 notification is due and payable. Payments under this Section
18 are not due and payable, however, until (i) the methodologies
19 described in this Section are approved by the federal
20 government in an appropriate State Plan amendment and (ii) the
21 assessment imposed under subsection (b-5) of Section 5A-2 of
22 this Article is determined to be a permissible tax under Title
23 XIX of the Social Security Act. For State fiscal year 2013, the
24 amount of the payments shall be prorated based on the portion
25 of the fiscal year for which they and the assessment authorized

1 under subsection (b-5) of Section 5A-2 are in effect.

2 (a-5) Accelerated schedule. The Illinois Department may,
3 when practicable, accelerate the schedule upon which payments
4 authorized under this Section are made.

5 (b) Magnet and perinatal hospital adjustment. In addition
6 to rates paid for inpatient hospital services, the Department
7 shall pay to each Illinois general acute care hospital that, as
8 of August 25, 2011, was recognized as a Magnet hospital by the
9 American Nurses Credentialing Center and that, as of September
10 14, 2011, was designated as a level III perinatal center
11 amounts as follows:

12 (1) For hospitals with a case mix index equal to or
13 greater than the 80th percentile of case mix indices for
14 all Illinois hospitals, \$380 for each Medicaid general
15 acute care inpatient day of care provided by the hospital
16 during State fiscal year 2009.

17 (2) For all other hospitals, \$200 for each Medicaid
18 general acute care inpatient day of care provided by the
19 hospital during State fiscal year 2009.

20 (c) Trauma level II adjustment. In addition to rates paid
21 for inpatient hospital services, the Department shall pay to
22 each Illinois general acute care hospital that, as of July 1,
23 2011, was designated as a level II trauma center amounts as
24 follows:

25 (1) For hospitals with a case mix index equal to or
26 greater than the 50th percentile of case mix indices for

1 all Illinois hospitals, \$380 for each Medicaid general
2 acute care inpatient day of care provided by the hospital
3 during State fiscal year 2009.

4 (2) For all other hospitals, \$135 for each Medicaid
5 general acute care inpatient day of care provided by the
6 hospital during State fiscal year 2009.

7 (3) For the purposes of this adjustment, hospitals
8 located in the same city that alternate their trauma center
9 designation as defined in 89 Ill. Adm. Code 148.295(a)(2)
10 shall have the adjustment provided under this section
11 divided between the 2 hospitals.

12 (d) Dual eligible adjustment. In addition to rates paid for
13 inpatient services, the Department shall pay each Illinois
14 general acute care hospital that had a ratio of crossover days
15 to total inpatient days for programs under Title XIX of the
16 Social Security Act administered by the Department (utilizing
17 information from 2009 paid claims) greater than 50%, and a case
18 mix index equal to or greater than the 75th percentile of case
19 mix indices for all Illinois hospitals, a rate of \$380 for each
20 Medicaid inpatient day during State fiscal year 2009 including
21 crossover days.

22 (e) Medicaid volume adjustment. In addition to rates paid
23 for inpatient hospital services, the Department shall pay to
24 each Illinois general acute care hospital that provided more
25 than 10,000 Medicaid inpatient days of care in State fiscal
26 year 2009, has a Medicaid inpatient utilization rate of at

1 least 29.05% as calculated by the Department for the Rate Year
2 2011 Disproportionate Share determination, and is not eligible
3 for Medicaid Percentage Adjustment payments in rate year 2012
4 an amount equal to \$75 for each Medicaid inpatient day of care
5 provided during State fiscal year 2009.

6 (f) Outpatient service adjustment. In addition to the rates
7 paid for outpatient hospital services, the Department shall pay
8 each Illinois hospital an amount at least equal to \$100
9 multiplied by the hospital's outpatient ambulatory procedure
10 listing services (excluding categories 3B and 3C) and by the
11 hospital's end stage renal disease treatment services provided
12 for State fiscal year 2009.

13 (g) Care coordination adjustment.

14 (1) In addition to the rates paid for outpatient
15 hospital services provided in the emergency department,
16 the Department shall pay each Illinois hospital an amount
17 equal to \$100 multiplied by the hospital's outpatient
18 ambulatory procedure listing services for categories 3A,
19 3B, and 3C for State fiscal year 2009.

20 (2) In addition to the rates paid for outpatient
21 hospital services, the Department shall pay each Illinois
22 freestanding psychiatric hospital an amount equal to \$100
23 multiplied by the hospital's ambulatory procedure listing
24 services for category 5A for State fiscal year 2009.

25 (3) In order to incentivize better coordination of care
26 for patients receiving emergency room services and

1 services related to behavioral health and substance abuse,
2 the Department may seek to have the care coordination
3 activities that are developed in consultation with a
4 statewide association representing hospitals and that are
5 supported by these adjustment payments considered under
6 Section 2703 of the Affordable Care Act.

7 (h) Specialty hospital adjustment. In addition to the rates
8 paid for outpatient hospital services, the Department shall pay
9 each Illinois long term acute care hospital and each Illinois
10 hospital devoted exclusively to the treatment of cancer, an
11 amount equal to \$715 multiplied by the hospital's outpatient
12 ambulatory procedure listing services and by the hospital's end
13 stage renal disease treatment services (including services
14 provided to individuals eligible for both Medicaid and
15 Medicare) provided for State fiscal year 2009.

16 (i) Physician supplemental adjustment. In addition to the
17 rates paid for physician services, the Department shall make an
18 adjustment payment for services provided by physicians as
19 follows:

20 (1) Physician services eligible for the adjustment
21 payment are those provided by physicians employed by or who
22 have an exclusive contract to provide services to patients
23 of the following hospitals: (i) Illinois general acute care
24 hospitals that provided at least 17,000 Medicaid inpatient
25 days of care in State fiscal year 2009 and had a Medicaid
26 inpatient utilization rate of at least 19.23% as calculated

1 by the Department for the Rate Year 2011 Disproportionate
2 Share determination; and (ii) Illinois freestanding
3 children's hospitals, as defined in 89 Ill. Adm. Code
4 149.50(c)(3)(A).

5 (2) The amount of the adjustment for each eligible
6 hospital under this subsection (i) shall be determined by
7 rule by the Department to spend a total pool of at least
8 \$22,000,000 annually. This pool shall be allocated among
9 the eligible hospitals based on the difference between the
10 upper payment limit for what could have been paid under
11 Medicaid for physician services provided during State
12 fiscal year 2009 by physicians employed by or who had an
13 exclusive contract with the hospital and the amount that
14 was paid under Medicaid for such services, provided
15 however, that in no event shall physicians at any
16 individual hospital collectively receive an annual,
17 aggregate adjustment in excess of \$1,000,000. Any amount
18 that is not distributed to a hospital because of the upper
19 payment limit shall be reallocated among the remaining
20 eligible hospitals that are below the upper payment
21 limitation, on a proportionate basis.

22 (j) For purposes of this Section, a hospital that is
23 enrolled to provide Medicaid services during State fiscal year
24 2009 shall have its utilization and associated reimbursements
25 annualized prior to the payment calculations being performed
26 under this Section.

1 (k) For purposes of this Section, the terms "Medicaid
2 days", "ambulatory procedure listing services", and
3 "ambulatory procedure listing payments" do not include any
4 days, charges, or services for which Medicare or a managed care
5 organization reimbursed on a capitated basis was liable for
6 payment, except where explicitly stated otherwise in this
7 Section.

8 (l) Definitions. Unless the context requires otherwise or
9 unless provided otherwise in this Section, the terms used in
10 this Section for qualifying criteria and payment calculations
11 shall have the same meanings as those terms have been given in
12 the Illinois Department's administrative rules as in effect on
13 October 1, 2011. Other terms shall be defined by the Illinois
14 Department by rule.

15 As used in this Section, unless the context requires
16 otherwise:

17 "Case mix index" means, for a given hospital, the sum of
18 the per admission (DRG) relative weighting factors in effect on
19 January 1, 2005, for all general acute care admissions for
20 State fiscal year 2009, excluding Medicare crossover
21 admissions and transplant admissions reimbursed under 89 Ill.
22 Adm. Code 148.82, divided by the total number of general acute
23 care admissions for State fiscal year 2009, excluding Medicare
24 crossover admissions and transplant admissions reimbursed
25 under 89 Ill. Adm. Code 148.82.

26 "Medicaid inpatient day" means, for a given hospital, the

1 sum of days of inpatient hospital days provided to recipients
2 of medical assistance under Title XIX of the federal Social
3 Security Act, excluding days for individuals eligible for
4 Medicare under Title XVIII of that Act (Medicaid/Medicare
5 crossover days), as tabulated from the Department's paid claims
6 data for admissions occurring during State fiscal year 2009
7 that was adjudicated by the Department through June 30, 2010.

8 "Outpatient ambulatory procedure listing services" means,
9 for a given hospital, ambulatory procedure listing services, as
10 described in 89 Ill. Adm. Code 148.140(b), provided to
11 recipients of medical assistance under Title XIX of the federal
12 Social Security Act, excluding services for individuals
13 eligible for Medicare under Title XVIII of the Act
14 (Medicaid/Medicare crossover days), as tabulated from the
15 Department's paid claims data for services occurring in State
16 fiscal year 2009 that were adjudicated by the Department
17 through September 2, 2010.

18 "Outpatient end-stage renal disease treatment services"
19 means, for a given hospital, the services, as described in 89
20 Ill. Adm. Code 148.140(c), provided to recipients of medical
21 assistance under Title XIX of the federal Social Security Act,
22 excluding payments for individuals eligible for Medicare under
23 Title XVIII of the Act (Medicaid/Medicare crossover days), as
24 tabulated from the Department's paid claims data for services
25 occurring in State fiscal year 2009 that were adjudicated by
26 the Department through September 2, 2010.

1 (m) The Department may adjust payments made under this
2 Section 5A-12.4 to comply with federal law or regulations
3 regarding hospital-specific payment limitations on
4 government-owned or government-operated hospitals.

5 (n) Notwithstanding any of the other provisions of this
6 Section, the Department is authorized to adopt rules that
7 change the hospital access improvement payments specified in
8 this Section, but only to the extent necessary to conform to
9 any federally approved amendment to the Title XIX State plan.
10 Any such rules shall be adopted by the Department as authorized
11 by Section 5-50 of the Illinois Administrative Procedure Act.
12 Notwithstanding any other provision of law, any changes
13 implemented as a result of this subsection (n) shall be given
14 retroactive effect so that they shall be deemed to have taken
15 effect as of the effective date of this Section.

16 (o) The Department of Healthcare and Family Services must
17 submit a State Medicaid Plan Amendment to the Centers of
18 Medicare and Medicaid Services to implement the payments under
19 this Section within 30 days of the effective date of this
20 amendatory Act of the 97th General Assembly.

21 (p) If any of the federal upper payment limits applicable
22 to the payments under this Section are exceeded due to an
23 expansion of the number of recipients enrolled in
24 fully-capitated, risk-based managed care arrangements prior to
25 the dates set forth in subsections (a) and (d) of Section
26 5A-14, the payments under this Section that exceed the

1 applicable federal upper payment limits may be reduced
2 uniformly to the extent necessary to comply with the applicable
3 federal upper payment limit.

4 (305 ILCS 5/5A-13)

5 Sec. 5A-13. Emergency rulemaking. The Department of
6 Healthcare and Family Services (formerly Department of Public
7 Aid) may adopt rules necessary to implement this amendatory Act
8 of the 94th General Assembly through the use of emergency
9 rulemaking in accordance with Section 5-45 of the Illinois
10 Administrative Procedure Act. For purposes of that Act, the
11 General Assembly finds that the adoption of rules to implement
12 this amendatory Act of the 94th General Assembly is deemed an
13 emergency and necessary for the public interest, safety, and
14 welfare.

15 The Department of Healthcare and Family Services may adopt
16 rules necessary to implement this amendatory Act of the 97th
17 General Assembly through the use of emergency rulemaking in
18 accordance with Section 5-45 of the Illinois Administrative
19 Procedure Act. For purposes of that Act, the General Assembly
20 finds that the adoption of rules to implement this amendatory
21 Act of the 97th General Assembly is deemed an emergency and
22 necessary for the public interest, safety, and welfare.

23 (Source: P.A. 94-242, eff. 7-18-05; 95-331, eff. 8-21-07.)

24 (305 ILCS 5/5A-14)

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

2 (a) Section 5A-2 is repealed on July 1, 2014.

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

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

5 (d) Section 5A-12.2 and Section 5A-12.4 are ~~is~~ repealed on
6 July 1, 2014.

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

8 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09;
9 96-1530, eff. 2-16-11.)

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

1 INDEX

2 Statutes amended in order of appearance

- 3 305 ILCS 5/5A-1 from Ch. 23, par. 5A-1
- 4 305 ILCS 5/5A-2 from Ch. 23, par. 5A-2
- 5 305 ILCS 5/5A-4 from Ch. 23, par. 5A-4
- 6 305 ILCS 5/5A-5 from Ch. 23, par. 5A-5
- 7 305 ILCS 5/5A-8 from Ch. 23, par. 5A-8
- 8 305 ILCS 5/5A-10 from Ch. 23, par. 5A-10
- 9 305 ILCS 5/5A-12.4 new
- 10 305 ILCS 5/5A-13
- 11 305 ILCS 5/5A-14