



Sen. Jeffrey M. Schoenberg

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1 AMENDMENT TO SENATE BILL 774

2 AMENDMENT NO. _____. Amend Senate Bill 774 by replacing
3 everything after the enacting clause with the following:

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

1 any other non-hospital based services as determined by the
2 Illinois Department by rule; and (ii) gross revenues
3 attributable to the routine services provided to persons
4 receiving skilled or intermediate long-term care services
5 within the meaning of Title XVIII or XIX of the Social Security
6 Act; and (iii) Medicare gross revenue (excluding the Medicare
7 gross revenue attributable to clauses (i) and (ii) of this
8 paragraph and the Medicare gross revenue attributable to the
9 routine services provided to patients in a psychiatric
10 hospital, a rehabilitation hospital, a distinct part
11 psychiatric unit, a distinct part rehabilitation unit, or swing
12 beds). Adjusted gross hospital revenue shall be determined
13 using the most recent data available from each hospital's 2003
14 Medicare cost report as contained in the Healthcare Cost Report
15 Information System file, for the quarter ending on December 31,
16 2004, without regard to any subsequent adjustments or changes
17 to such data. If a hospital's 2003 Medicare cost report is not
18 contained in the Healthcare Cost Report Information System, the
19 hospital provider shall furnish such cost report or the data
20 necessary to determine its adjusted gross hospital revenue as
21 required by rule by the Illinois Department.

22 "Fund" means the Hospital Provider Fund.

23 "Hospital" means an institution, place, building, or
24 agency located in this State that is subject to licensure by
25 the Illinois Department of Public Health under the Hospital
26 Licensing Act, whether public or private and whether organized

1 for profit or not-for-profit.

2 "Hospital provider" means a person licensed by the
3 Department of Public Health to conduct, operate, or maintain a
4 hospital, regardless of whether the person is a Medicaid
5 provider. For purposes of this paragraph, "person" means any
6 political subdivision of the State, municipal corporation,
7 individual, firm, partnership, corporation, company, limited
8 liability company, association, joint stock association, or
9 trust, or a receiver, executor, trustee, guardian, or other
10 representative appointed by order of any court.

11 "Medicare bed days" means, for each hospital, the sum of
12 the number of days that each bed was occupied by a patient who
13 was covered by Title XVIII of the Social Security Act,
14 excluding days attributable to the routine services provided to
15 persons receiving skilled or intermediate long term care
16 services. Medicare bed days shall be computed separately for
17 each hospital operated or maintained by a hospital provider.

18 "Occupied bed days" means the sum of the number of days
19 that each bed was occupied by a patient for all beds, excluding
20 days attributable to the routine services provided to persons
21 receiving skilled or intermediate long term care services.
22 Occupied bed days shall be computed separately for each
23 hospital operated or maintained by a hospital provider.

24 "Outpatient gross revenue" means, for each hospital, its
25 total gross charges attributed to outpatient services as
26 reported on the Medicare cost report at Worksheet C, Part I,

1 Column 7, line 101, less the sum of lines 45, 60, 63, 64, 65,
2 66, 67, and 68 (and any subsets of those lines).

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

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

6 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

8 Sec. 5A-2. Assessment.

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

15 For State fiscal years 2004 and 2005, the Department of
16 Healthcare and Family Services shall use the number of occupied
17 bed days as reported by each hospital on the Annual Survey of
18 Hospitals conducted by the Department of Public Health to
19 calculate the hospital's annual assessment. If the sum of a
20 hospital's occupied bed days is not reported on the Annual
21 Survey of Hospitals or if there are data errors in the reported
22 sum of a hospital's occupied bed days as determined by the
23 Department of Healthcare and Family Services (formerly
24 Department of Public Aid), then the Department of Healthcare
25 and Family Services may obtain the sum of occupied bed days

1 from any source available, including, but not limited to,
2 records maintained by the hospital provider, which may be
3 inspected at all times during business hours of the day by the
4 Department of Healthcare and Family Services or its duly
5 authorized agents and employees.

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

21 Subject to Sections 5A-3 and 5A-10, for State fiscal years
22 2009 through 2014, an annual assessment on inpatient services
23 is imposed on each hospital provider in an amount equal to
24 \$218.38 multiplied by the difference of the hospital's occupied
25 bed days less the hospital's Medicare bed days.

26 For State fiscal years 2009 through 2014, a hospital's

1 occupied bed days and Medicare bed days shall be determined
2 using the most recent data available from each hospital's 2005
3 Medicare cost report as contained in the Healthcare Cost Report
4 Information System file, for the quarter ending on December 31,
5 2006, without regard to any subsequent adjustments or changes
6 to such data. If a hospital's 2005 Medicare cost report is not
7 contained in the Healthcare Cost Report Information System,
8 then the Illinois Department may obtain the hospital provider's
9 occupied bed days and Medicare bed days from any source
10 available, including, but not limited to, records maintained by
11 the hospital provider, which may be inspected at all times
12 during business hours of the day by the Illinois Department or
13 its duly authorized agents and employees.

14 (b) (Blank).

15 (b-5) Subject to Sections 5A-3 and 5A-10, for State fiscal
16 years 2012 through 2014, an annual assessment on outpatient
17 services is imposed on each hospital provider in an amount
18 equal to .007236 multiplied by the hospital's outpatient gross
19 revenue. For State fiscal year 2012, the amount of the
20 assessment shall be prorated based on the portion of the fiscal
21 year for which it and the payments authorized under Section
22 5A-12.4 are in effect.

23 For State fiscal years 2012 through 2014, a hospital's
24 outpatient gross revenue shall be determined using the most
25 recent data available from each hospital's 2009 Medicare cost
26 report as contained in the Healthcare Cost Report Information

1 System file, for the quarter ending on June 30, 2011, without
2 regard to any subsequent adjustments or changes to such data.
3 If a hospital's 2009 Medicare cost report is not contained in
4 the Healthcare Cost Report Information System, then the
5 Department may obtain the hospital provider's outpatient gross
6 revenue from any source available, including, but not limited
7 to, records maintained by the hospital provider, which may be
8 inspected at all times during business hours of the day by the
9 Department or its duly authorized agents and employees.

10 (c) (Blank).

11 (d) Notwithstanding any of the other provisions of this
12 Section, the Department is authorized, during this 94th General
13 Assembly, to adopt rules to reduce the rate of any annual
14 assessment imposed under this Section, as authorized by Section
15 5-46.2 of the Illinois Administrative Procedure Act.

16 (e) Notwithstanding any other provision of this Section,
17 any plan providing for an assessment on a hospital provider as
18 a permissible tax under Title XIX of the federal Social
19 Security Act and Medicaid-eligible payments to hospital
20 providers from the revenues derived from that assessment shall
21 be reviewed by the Illinois Department of Healthcare and Family
22 Services, as the Single State Medicaid Agency required by
23 federal law, to determine whether those assessments and
24 hospital provider payments meet federal Medicaid standards. If
25 the Department determines that the elements of the plan may
26 meet federal Medicaid standards and a related State Medicaid

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

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

16 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

18 (a) The annual assessment imposed by Section 5A-2 for State
19 fiscal year 2004 shall be due and payable on June 18 of the
20 year. The assessment imposed by Section 5A-2 for State fiscal
21 year 2005 shall be due and payable in quarterly installments,
22 each equalling one-fourth of the assessment for the year, on
23 July 19, October 19, January 18, and April 19 of the year. The
24 assessment imposed by Section 5A-2 for State fiscal years 2006
25 through 2008 shall be due and payable in quarterly

1 installments, each equaling one-fourth of the assessment for
2 the year, on the fourteenth State business day of September,
3 December, March, and May. Except as provided in subsection
4 (a-5) of this Section, the assessment imposed by Section 5A-2
5 for State fiscal year 2009 and each subsequent State fiscal
6 year shall be due and payable in monthly installments, each
7 equaling one-twelfth of the assessment for the year, on the
8 fourteenth State business day of each month. No installment
9 payment of an assessment imposed by Section 5A-2 shall be due
10 and payable, however, until after: (i) the Department notifies
11 the hospital provider, in writing, that the payment
12 methodologies to hospitals required under Section 5A-12,
13 Section 5A-12.1, or Section 5A-12.2, whichever is applicable
14 for that fiscal year, have been approved by the Centers for
15 Medicare and Medicaid Services of the U.S. Department of Health
16 and Human Services and the waiver under 42 CFR 433.68 for the
17 assessment imposed by Section 5A-2, if necessary, has been
18 granted by the Centers for Medicare and Medicaid Services of
19 the U.S. Department of Health and Human Services; and (ii) the
20 Comptroller has issued the payments required under Section
21 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is
22 applicable for that fiscal year. Upon notification to the
23 Department of approval of the payment methodologies required
24 under Section 5A-12, Section 5A-12.1, or Section 5A-12.2,
25 whichever is applicable for that fiscal year, and the waiver
26 granted under 42 CFR 433.68, all installments otherwise due

1 under Section 5A-2 prior to the date of notification shall be
2 due and payable to the Department upon written direction from
3 the Department and issuance by the Comptroller of the payments
4 required under Section 5A-12.1 or Section 5A-12.2, whichever is
5 applicable for that fiscal year.

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

1 5A-2 prior to the date of notification shall be due and payable
2 to the Department upon written direction from the Department
3 and issuance by the Comptroller of the payments required under
4 Section 5A-12.4.

5 (a-5) The Illinois Department may, ~~for the purpose of~~
6 ~~maximizing federal revenue,~~ accelerate the schedule upon which
7 assessment installments are due and payable by hospitals with a
8 payment ratio greater than or equal to one. Such acceleration
9 of due dates for payment of the assessment may be made only in
10 conjunction with a corresponding acceleration in access
11 payments identified in Section 5A-12.2 or Section 5A-12.4 to
12 the same hospitals. For the purposes of this subsection (a-5),
13 a hospital's payment ratio is defined as the quotient obtained
14 by dividing the total payments for the State fiscal year, as
15 authorized under Section 5A-12.2 or Section 5A-12.4, by the
16 total assessment for the State fiscal year imposed under
17 Section 5A-2 or subsection (b-5) of Section 5A-2.

18 (b) The Illinois Department is authorized to establish
19 delayed payment schedules for hospital providers that are
20 unable to make installment payments when due under this Section
21 due to financial difficulties, as determined by the Illinois
22 Department.

23 (c) If a hospital provider fails to pay the full amount of
24 an installment when due (including any extensions granted under
25 subsection (b)), there shall, unless waived by the Illinois
26 Department for reasonable cause, be added to the assessment

1 imposed by Section 5A-2 a penalty assessment equal to the
2 lesser of (i) 5% of the amount of the installment not paid on
3 or before the due date plus 5% of the portion thereof remaining
4 unpaid on the last day of each 30-day period thereafter or (ii)
5 100% of the installment amount not paid on or before the due
6 date. For purposes of this subsection, payments will be
7 credited first to unpaid installment amounts (rather than to
8 penalty or interest), beginning with the most delinquent
9 installments.

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

17 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
18 96-821, eff. 11-20-09.)

19 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)

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

21 (a) The Department of Healthcare and Family Services shall
22 send a notice of assessment to every hospital provider subject
23 to assessment under this Article. The notice of assessment
24 shall notify the hospital of its assessment and shall be sent
25 after receipt by the Department of notification from the

1 Centers for Medicare and Medicaid Services of the U.S.
2 Department of Health and Human Services that the payment
3 methodologies required under Section 5A-12, Section 5A-12.1,
4 or Section 5A-12.2, or Section 5A-12.4, whichever is applicable
5 for that fiscal year, and, if necessary, the waiver granted
6 under 42 CFR 433.68 have been approved. The notice shall be on
7 a form 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, ~~or~~ 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 2004 and 2005, in the case of a hospital
24 provider that did not conduct, operate, or maintain a hospital
25 throughout calendar year 2001, the assessment for that State
26 fiscal year shall be computed on the basis of hypothetical

1 occupied bed days for the full calendar year as determined by
2 the Illinois Department. Notwithstanding any other provision
3 in this Article, for State fiscal years 2006 through 2008, in
4 the case of a hospital provider that did not conduct, operate,
5 or maintain a hospital in 2003, the assessment for that State
6 fiscal year shall be computed on the basis of hypothetical
7 adjusted gross hospital revenue for the hospital's first full
8 fiscal year as determined by the Illinois Department (which may
9 be based on annualization of the provider's actual revenues for
10 a portion of the year, or revenues of a comparable hospital for
11 the year, including revenues realized by a prior provider of
12 the same hospital during the year). Notwithstanding any other
13 provision in this Article, for State fiscal years 2009 through
14 2014, in the case of a hospital provider that did not conduct,
15 operate, or maintain a hospital in 2005, the assessment for
16 that State fiscal year shall be computed on the basis of
17 hypothetical occupied bed days for the full calendar year as
18 determined by the Illinois Department. Notwithstanding any
19 other provision in this Article, for State fiscal years 2012
20 through 2014, in the case of a hospital provider that did not
21 conduct, operate, or maintain a hospital in 2009, the
22 assessment under subsection (b-5) of Section 5A-2 for that
23 State fiscal year shall be computed on the basis of
24 hypothetical gross outpatient revenue for the full calendar
25 year as determined by the Illinois Department.

26 (f) Every hospital provider subject to assessment under

1 this Article shall keep sufficient records to permit the
2 determination of adjusted gross hospital revenue for the
3 hospital's fiscal year. All such records shall be kept in the
4 English language and shall, at all times during regular
5 business hours of the day, be subject to inspection by the
6 Illinois Department or its duly authorized agents and
7 employees.

8 (g) The Illinois Department may, by rule, provide a
9 hospital provider a reasonable opportunity to request a
10 clarification or correction of any clerical or computational
11 errors contained in the calculation of its assessment, but such
12 corrections shall not extend to updating the cost report
13 information used to calculate the assessment.

14 (h) (Blank).

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

17 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

23 (b) The Fund is created for the purpose of receiving moneys
24 in accordance with Section 5A-6 and disbursing moneys only for
25 the following purposes, notwithstanding any other provision of

1 law:

2 (1) For making payments to hospitals as required under
3 Articles V, V-A, VI, and XIV of this Code, under the
4 Children's Health Insurance Program Act, under the
5 Covering ALL KIDS Health Insurance Act, and under the
6 Senior Citizens and Disabled Persons Property Tax Relief
7 and Pharmaceutical Assistance Act.

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

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

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

18 (5) For making transfers, as those transfers are
19 authorized in the proceedings authorizing debt under the
20 Short Term Borrowing Act, but transfers made under this
21 paragraph (5) shall not exceed the principal amount of debt
22 issued in anticipation of the receipt by the State of
23 moneys to be deposited into the Fund.

24 (6) For making transfers to any other fund in the State
25 treasury, but transfers made under this paragraph (6) shall
26 not exceed the amount transferred previously from that

1 other fund into the Hospital Provider Fund.

2 (6.5) For making transfers to the Healthcare Provider
3 Relief Fund, except that transfers made under this
4 paragraph (6.5) shall not exceed \$60,000,000 in the
5 aggregate.

6 (7) For State fiscal years 2004 and 2005 for making
7 transfers to the Health and Human Services Medicaid Trust
8 Fund, including 20% of the moneys received from hospital
9 providers under Section 5A-4 and transferred into the
10 Hospital Provider Fund under Section 5A-6. For State fiscal
11 year 2006 for making transfers to the Health and Human
12 Services Medicaid Trust Fund of up to \$130,000,000 per year
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. Transfers under this paragraph
16 shall be made within 7 days after the payments have been
17 received pursuant to the schedule of payments provided in
18 subsection (a) of Section 5A-4.

19 (7.5) For State fiscal year 2007 for making transfers
20 of the moneys received from hospital providers under
21 Section 5A-4 and transferred into the Hospital Provider
22 Fund under Section 5A-6 to the designated funds not
23 exceeding the following amounts in that State fiscal year:

24	Health and Human Services	
25	Medicaid Trust Fund	\$20,000,000
26	Long-Term Care Provider Fund	\$30,000,000

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

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

6 (7.8) For State fiscal year 2008, for making transfers
7 of the moneys received from hospital providers under
8 Section 5A-4 and transferred into the Hospital Provider
9 Fund under Section 5A-6 to the designated funds not
10 exceeding the following amounts in that State fiscal year:

- 11 Health and Human Services
- 12 Medicaid Trust Fund \$40,000,000
- 13 Long-Term Care Provider Fund \$60,000,000
- 14 General Revenue Fund \$160,000,000.

15 Transfers under this paragraph shall be made within 7
16 days after the payments have been received pursuant to the
17 schedule of payments provided in subsection (a) of Section
18 5A-4.

19 (7.9) For State fiscal years 2009 through 2014, for
20 making transfers of the moneys received from hospital
21 providers under Section 5A-4 and transferred into the
22 Hospital Provider Fund under Section 5A-6 to the designated
23 funds not exceeding the following amounts in that State
24 fiscal year:

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

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

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

3 Except as provided under this paragraph, transfers
4 under this paragraph shall be made within 7 business days
5 after the payments have been received pursuant to the
6 schedule of payments provided in subsection (a) of Section
7 5A-4. For State fiscal year 2009, transfers to the General
8 Revenue Fund under this paragraph shall be made on or
9 before June 30, 2009, as sufficient funds become available
10 in the Hospital Provider Fund to both make the transfers
11 and continue hospital payments.

12 (7.10) For State fiscal year 2012, for making transfers
13 of the moneys resulting from the assessment under
14 subsection (b-5) of Section 5A-2 and received from hospital
15 providers under Section 5A-4 and transferred into the
16 Hospital Provider Fund under Section 5A-6 to the designated
17 funds not exceeding the following amounts in that State
18 fiscal year:

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

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

24 (7.11) For State fiscal years 2013 and 2014, for making
25 transfers of the moneys resulting from the assessment under
26 subsection (b-5) of Section 5A-2 and received from hospital

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

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

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

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

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

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

18 (1) All moneys collected or received by the Illinois
19 Department from the hospital provider assessment imposed
20 by this Article.

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

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

1 (4) Moneys transferred from another fund in the State
2 treasury.

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

5 (d) (Blank).

6 (Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3,
7 eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09;
8 96-1530, eff. 2-16-11.)

9 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

10 Sec. 5A-10. Applicability.

11 (a) The assessment imposed by subsection (a) of Section
12 5A-2 shall not take effect or shall cease to be imposed, and
13 any moneys remaining in the Fund shall be refunded to hospital
14 providers in proportion to the amounts paid by them, if:

15 (1) The sum of the appropriations for State fiscal
16 years 2004 and 2005 from the General Revenue Fund for
17 hospital payments under the medical assistance program is
18 less than \$4,500,000,000 or the appropriation for each of
19 State fiscal years 2006, 2007 and 2008 from the General
20 Revenue Fund for hospital payments under the medical
21 assistance program is less than \$2,500,000,000 increased
22 annually to reflect any increase in the number of
23 recipients, or the annual appropriation for State fiscal
24 years 2009, 2010, 2011, 2013, and 2014, from the General
25 Revenue Fund combined with the Hospital Provider Fund as

1 authorized in Section 5A-8 for hospital payments under the
2 medical assistance program, is less than the amount
3 appropriated for State fiscal year 2009, adjusted annually
4 to reflect any change in the number of recipients,
5 excluding State fiscal year 2009 supplemental
6 appropriations made necessary by the enactment of the
7 American Recovery and Reinvestment Act of 2009; or

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

20 (2.1) For State fiscal years 2009 through 2014, the
21 Department of Healthcare and Family Services adopts any
22 administrative rule change to reduce payment rates or
23 alters any payment methodology that reduces any payment
24 rates made to operating hospitals under the approved Title
25 XIX or Title XXI State plan in effect January 1, 2008
26 except for:

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

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

5 (C) any changes proposed in State plan amendment
6 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
7 08-07; or

8 (D) in relation to any admissions on or after
9 January 1, 2011, a modification in the methodology for
10 calculating outlier payments to hospitals for
11 exceptionally costly stays, for hospitals reimbursed
12 under the diagnosis-related grouping methodology;
13 provided that the Department shall be limited to one
14 such modification during the 36-month period after the
15 effective date of this amendatory Act of the 96th
16 General Assembly; or

17 (3) The payments to hospitals required under Section
18 5A-12 or Section 5A-12.2 are changed or are not eligible
19 for federal matching funds under Title XIX or XXI of the
20 Social Security Act.

21 (b) The assessment imposed by Section 5A-2 shall not take
22 effect or shall cease to be imposed if the assessment is
23 determined to be an impermissible tax under Title XIX of the
24 Social Security Act. Moneys in the Hospital Provider Fund
25 derived from assessments imposed prior thereto shall be
26 disbursed in accordance with Section 5A-8 to the extent federal

1 financial participation is not reduced due to the
2 impermissibility of the assessments, and any remaining moneys
3 shall be refunded to hospital providers in proportion to the
4 amounts paid by them.

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

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

16 (1) for State fiscal years 2012 through 2014, the
17 Department reduces any payment rates to hospitals as in
18 effect on November 1, 2011, or alters any payment
19 methodology as in effect on November 1, 2011, that has the
20 effect of reducing payment rates to hospitals; or

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

26 (e) If the payments under Section 5A-12.4 are reduced

1 pursuant to subsection (p) of Section 5A-12.4, then the
2 assessment rate imposed under subsection (b-5) of Section 5A-2
3 shall be reduced such that the aggregate assessment is reduced
4 by 50% of the amount of any reduction in payments pursuant to
5 subsection (p) of Section 5A-12.4.

6 (Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72,
7 eff. 7-1-11; 97-74, eff. 6-30-11.)

8 (305 ILCS 5/5A-12.4 new)

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

11 (a) Hospital access improvement payments. To preserve and
12 improve access to hospital services, for hospital and physician
13 services rendered on or after January 1, 2012, the Illinois
14 Department shall, except for hospitals described in subsection
15 (b) of Section 5A-3, make payments to hospitals as set forth in
16 this Section. These payments shall be paid in 12 equal
17 installments on or before the 7th State business day of each
18 month, except that no payment shall be due within 100 days
19 after the later of the date of notification of federal approval
20 of the payment methodologies required under this Section or any
21 waiver required under 42 CFR 433.68, at which time the sum of
22 amounts required under this Section prior to the date of
23 notification is due and payable. Payments under this Section
24 are not due and payable, however, until (i) the methodologies
25 described in this Section are approved by the federal

1 government in an appropriate State Plan amendment and (ii) the
2 assessment imposed under subsection (b-5) of Section 5A-2 of
3 this Article is determined to be a permissible tax under Title
4 XIX of the Social Security Act. For State fiscal year 2012, the
5 amount of the payments shall be prorated based on the portion
6 of the fiscal year for which they and the assessment authorized
7 under subsection (b-5) of Section 5A-2 are in effect.

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

11 (b) Magnet and perinatal hospital adjustment. In addition
12 to rates paid for inpatient hospital services, the Department
13 shall pay to each Illinois general acute care hospital that, as
14 of August 25, 2011, was recognized as a Magnet hospital by the
15 American Nurses Credentialing Center and that, as of September
16 14, 2011, was designated as a level III perinatal center
17 amounts as follows:

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

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

26 (c) Trauma level II adjustment. In addition to rates paid

1 for inpatient hospital services, the Department shall pay to
2 each Illinois general acute care hospital that, as of July 1,
3 2011, was designated as a level II trauma center amounts as
4 follows:

5 (1) For hospitals with a case mix index equal to or
6 greater than the 50th percentile of case mix indices for
7 all Illinois hospitals, \$380 for each Medicaid general
8 acute care inpatient day of care provided by the hospital
9 during State fiscal year 2009.

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

13 (3) For the purposes of this adjustment, hospitals
14 located in the same city that alternate their trauma center
15 designation as defined in 89 Ill. Adm. Code 148.295(a)(2)
16 shall have the adjustment provided under this section
17 divided between the 2 hospitals.

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

1 crossover days.

2 (e) Medicaid volume adjustment. In addition to rates paid
3 for inpatient hospital services, the Department shall pay to
4 each Illinois general acute care hospital that provided more
5 than 10,000 Medicaid inpatient days of care in State fiscal
6 year 2009, has a Medicaid inpatient utilization rate of at
7 least 29.05% as calculated by the Department for the Rate Year
8 2011 Disproportionate Share determination, and is not eligible
9 for Medicaid Percentage Adjustment payments in rate year 2011
10 an amount equal to \$75 for each Medicaid inpatient day of care
11 provided during State fiscal year 2009.

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

19 (g) Care coordination adjustment.

20 (1) In addition to the rates paid for outpatient
21 hospital services provided in the emergency department,
22 the Department shall pay each Illinois hospital an amount
23 equal to \$100 multiplied by the hospital's outpatient
24 ambulatory procedure listing services for categories 3A,
25 3B, and 3C for State fiscal year 2009.

26 (2) In addition to the rates paid for outpatient

1 hospital services, the Department shall pay each Illinois
2 freestanding psychiatric hospital an amount equal to \$100
3 multiplied by the hospital's ambulatory procedure listing
4 services for category 5A for State fiscal year 2009.

5 (3) In order to incentivize better coordination of care
6 for patients receiving emergency room services and
7 services related to behavioral health and substance abuse,
8 the Department may seek to have the care coordination
9 activities that are developed in consultation with a
10 statewide association representing hospitals and that are
11 supported by these adjustment payments considered under
12 Section 2703 of the Affordable Care Act.

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

22 (i) Physician supplemental adjustment. In addition to the
23 rates paid for physician services, the Department shall make an
24 adjustment payment for services provided by physicians as
25 follows:

26 (1) Physician services eligible for the adjustment

1 payment are those provided by physicians employed by or who
2 have an exclusive contract to provide services to patients
3 of the following hospitals: (i) Illinois general acute care
4 hospitals that provided at least 17,000 Medicaid inpatient
5 days of care in State fiscal year 2009 and had a Medicaid
6 inpatient utilization rate of at least 19.23% as calculated
7 by the Department for the Rate Year 2011 Disproportionate
8 Share determination; and (ii) Illinois freestanding
9 children's hospitals, as defined in 89 Ill. Adm. Code
10 149.50(c)(3)(A).

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

1 limitation, on a proportionate basis.

2 (j) For purposes of this Section, a hospital that is
3 enrolled to provide Medicaid services during State fiscal year
4 2009 shall have its utilization and associated reimbursements
5 annualized prior to the payment calculations being performed
6 under this Section.

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

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

21 As used in this Section, unless the context requires
22 otherwise:

23 "Case mix index" means, for a given hospital, the sum of
24 the per admission (DRG) relative weighting factors in effect on
25 January 1, 2005, for all general acute care admissions for
26 State fiscal year 2009, excluding Medicare crossover

1 admissions and transplant admissions reimbursed under 89 Ill.
2 Adm. Code 148.82, divided by the total number of general acute
3 care admissions for State fiscal year 2009, excluding Medicare
4 crossover admissions and transplant admissions reimbursed
5 under 89 Ill. Adm. Code 148.82.

6 "Medicaid inpatient day" means, for a given hospital, the
7 sum of days of inpatient hospital days provided to recipients
8 of medical assistance under Title XIX of the federal Social
9 Security Act, excluding days for individuals eligible for
10 Medicare under Title XVIII of that Act (Medicaid/Medicare
11 crossover days), as tabulated from the Department's paid claims
12 data for admissions occurring during State fiscal year 2009
13 that was adjudicated by the Department through June 30, 2010.

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

24 "Outpatient end-stage renal disease treatment services"
25 means, for a given hospital, the services, as described in 89
26 Ill. Adm. Code 148.140(c), provided to recipients of medical

1 assistance under Title XIX of the federal Social Security Act,
2 excluding payments for individuals eligible for Medicare under
3 Title XVIII of the Act (Medicaid/Medicare crossover days), as
4 tabulated from the Department's paid claims data for services
5 occurring in State fiscal year 2009 that were adjudicated by
6 the Department through September 2, 2010.

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

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

22 (o) The Department of Healthcare and Family Services must
23 submit a State Medicaid Plan Amendment to the Centers of
24 Medicare and Medicaid Services to implement the payments under
25 this Section within 30 days of the effective date of this Act.

26 (p) If any of the federal upper payment limits applicable

1 to the payments under this Section are exceeded due to an
2 expansion of the number of recipients enrolled in
3 fully-capitated, risk-based managed care arrangements prior to
4 the dates set forth in subsections (a) and (d) of Section
5 5A-14, the payments under this Section that exceed the
6 applicable federal upper payment limits may be reduced
7 uniformly to the extent necessary to comply with the applicable
8 federal upper payment limit.

9 (305 ILCS 5/5A-13)

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

20 The Department of Healthcare and Family Services may adopt
21 rules necessary to implement this amendatory Act of the 97th
22 General Assembly through the use of emergency rulemaking in
23 accordance with Section 5-45 of the Illinois Administrative
24 Procedure Act. For purposes of that Act, the General Assembly
25 finds that the adoption of rules to implement this amendatory

1 Act of the 97th General Assembly is deemed an emergency and
2 necessary for the public interest, safety, and welfare.

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

4 (305 ILCS 5/5A-14)

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

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

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

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

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

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

12 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09;
13 96-1530, eff. 2-16-11.)

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