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 1. Findings. The General Assembly finds it is in
5 the best interests of the State to take advantage of the
6 Patient Protection and Affordable Care Act to enable Illinois
7 to receive enhanced federal revenue to cover the costs of
8 health care for low-income adults who are otherwise not
9 eligible for Medicaid. The General Assembly further finds that
10 the administration and financing of the Medicaid program must
11 be sound to ensure Illinois may take full advantage of national
12 health care reform to keep people healthier; reimburse
13 hospitals and clinics for uncompensated and charity care for
14 the uninsured; and replace spending by county and local
15 governments for healthcare costs now borne by local health
16 departments, social service agencies, homeless shelters,
17 mental health clinics, drug treatment centers, township
18 organizations, and others for the care of the uninsured.
19 Accordingly, the General Assembly finds that, while filling the
20 current gap in Medicaid coverage, it is essential that the
21 State preserve and extend recent efforts to reform Illinois'
22 Medicaid program. Changes designed to increase efficiencies
23 and enhance program integrity must continue to prevent client
24 and provider fraud and abuse; to impose controls on use of

1 Medicaid services to prevent over-use or waste; to rationalize
2 the Medicaid health care delivery system by adopting care
3 coordination models wherever feasible to achieve effective and
4 efficient care delivery across all covered services; and to
5 operate the program within budget limits.

6 Section 5. The Illinois Public Aid Code is amended by
7 changing Sections 5-1.1, 5-1.4, 5-2, 5A-2, 5A-4, 5A-5, 5A-8,
8 and 5A-12.4 as follows:

9 (305 ILCS 5/5-1.1) (from Ch. 23, par. 5-1.1)
10 Sec. 5-1.1. Definitions. The terms defined in this Section
11 shall have the meanings ascribed to them, except when the
12 context otherwise requires.
13 (a) "Nursing facility" means a facility, licensed by the
14 Department of Public Health under the Nursing Home Care Act,
15 that provides nursing facility services within the meaning of
16 Title XIX of the federal Social Security Act.
17 (b) "Intermediate care facility for the developmentally
18 disabled" or "ICF/DD" means a facility, licensed by the
19 Department of Public Health under the ID/DD Community Care Act,
20 that is an intermediate care facility for the mentally retarded
21 within the meaning of Title XIX of the federal Social Security
22 Act.
23 (c) "Standard services" means those services required for
24 the care of all patients in the facility and shall, as a

minimum, include the following: (1) administration; (2) dietary (standard); (3) housekeeping; (4) laundry and linen; (5) maintenance of property and equipment, including utilities; (6) medical records; (7) training of employees; (8) utilization review; (9) activities services; (10) social services; (11) disability services; and all other similar services required by either the laws of the State of Illinois or one of its political subdivisions or municipalities or by Title XIX of the Social Security Act.

(d) "Patient services" means those which vary with the number of personnel; professional and para-professional skills of the personnel; specialized equipment, and reflect the intensity of the medical and psycho-social needs of the patients. Patient services shall as a minimum include: (1) physical services; (2) nursing services, including restorative nursing; (3) medical direction and patient care planning; (4) health related supportive and habilitative services and all similar services required by either the laws of the State of Illinois or one of its political subdivisions or municipalities or by Title XIX of the Social Security Act.

(e) "Ancillary services" means those services which require a specific physician's order and defined as under the medical assistance program as not being routine in nature for skilled nursing facilities and ICF/DDs. Such services generally must be authorized prior to delivery and payment as provided for under the rules of the Department of Healthcare

1 and Family Services.

2 (f) "Capital" means the investment in a facility's assets
3 for both debt and non-debt funds. Non-debt capital is the
4 difference between an adjusted replacement value of the assets
5 and the actual amount of debt capital.

6 (g) "Profit" means the amount which shall accrue to a
7 facility as a result of its revenues exceeding its expenses as
8 determined in accordance with generally accepted accounting
9 principles.

10 (h) "Non-institutional services" means those services
11 provided under paragraph (f) of Section 3 of the Disabled
12 Persons Rehabilitation Act and those services provided under
13 Section 4.02 of the Illinois Act on the Aging.

14 (i) (Blank).

15 (j) "Institutionalized person" means an individual who is
16 an inpatient in an ICF/DD or nursing facility, or who is an
17 inpatient in a medical institution receiving a level of care
18 equivalent to that of an ICF/DD or nursing facility, or who is
19 receiving services under Section 1915(c) of the Social Security
20 Act.

21 (k) "Institutionalized spouse" means an institutionalized
22 person who is expected to receive services at the same level of
23 care for at least 30 days and is married to a spouse who is not
24 an institutionalized person.

25 (l) "Community spouse" is the spouse of an
26 institutionalized spouse.

1 (m) "Health Benefits Service Package" means, subject to
2 federal approval, benefits covered by the medical assistance
3 program as determined by the Department by rule for individuals
4 eligible for medical assistance under paragraph 18 of Section
5 5-2 of this Code.
6 (Source: P.A. 96-1530, eff. 2-16-11; 97-227, eff. 1-1-12;
7 97-820, eff. 7-17-12.)

8 (305 ILCS 5/5-1.4)
9 Sec. 5-1.4. Moratorium on eligibility expansions.
10 Beginning on January 25, 2011 (the effective date of Public Act
11 96-1501), there shall be a 4-year moratorium on the expansion
12 of eligibility through increasing financial eligibility
13 standards, or through increasing income disregards, or through
14 the creation of new programs which would add new categories of
15 eligible individuals under the medical assistance program in
16 addition to those categories covered on January 1, 2011 or
17 above the level of any subsequent reduction in eligibility.
18 This moratorium shall not apply to expansions required as a
19 federal condition of State participation in the medical
20 assistance program or to expansions approved by the federal
21 government that are financed entirely by units of local
22 government and federal matching funds. If the State of Illinois
23 finds that the State has borne a cost related to such an
24 expansion, the unit of local government shall reimburse the
25 State. All federal funds associated with an expansion funded by

1 a unit of local government shall be returned to the local
2 government entity funding the expansion, pursuant to an
3 intergovernmental agreement between the Department of
4 Healthcare and Family Services and the local government entity.
5 Within 10 calendar days of the effective date of this
6 amendatory Act of the 97th General Assembly, the Department of
7 Healthcare and Family Services shall formally advise the
8 Centers for Medicare and Medicaid Services of the passage of
9 this amendatory Act of the 97th General Assembly. The State is
10 prohibited from submitting additional waiver requests that
11 expand or allow for an increase in the classes of persons
12 eligible for medical assistance under this Article to the
13 federal government for its consideration beginning on the 20th
14 calendar day following the effective date of this amendatory
15 Act of the 97th General Assembly until January 25, 2015. This
16 moratorium shall not apply to those persons eligible for
17 medical assistance pursuant to 42 U.S.C.
18 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
19 Section 5-2 of this Code.
20 (Source: P.A. 96-1501, eff. 1-25-11; 97-687, eff. 6-14-12.)

21 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)
22 Sec. 5-2. Classes of Persons Eligible. Medical assistance
23 under this Article shall be available to any of the following
24 classes of persons in respect to whom a plan for coverage has
25 been submitted to the Governor by the Illinois Department and

1 approved by him:
2 1. Recipients of basic maintenance grants under
3 Articles III and IV.
4 2. Persons otherwise eligible for basic maintenance
5 under Articles III and IV, excluding any eligibility
6 requirements that are inconsistent with any federal law or
7 federal regulation, as interpreted by the U.S. Department
8 of Health and Human Services, but who fail to qualify
9 thereunder on the basis of need or who qualify but are not
10 receiving basic maintenance under Article IV, and who have
11 insufficient income and resources to meet the costs of
12 necessary medical care, including but not limited to the
13 following:
14 (a) All persons otherwise eligible for basic
15 maintenance under Article III but who fail to qualify
16 under that Article on the basis of need and who meet
17 either of the following requirements:
18 (i) their income, as determined by the
19 Illinois Department in accordance with any federal
20 requirements, is equal to or less than 70% in
21 fiscal year 2001, equal to or less than 85% in
22 fiscal year 2002 and until a date to be determined
23 by the Department by rule, and equal to or less
24 than 100% beginning on the date determined by the
25 Department by rule, of the nonfarm income official
26 poverty line, as defined by the federal Office of

1 Management and Budget and revised annually in
2 accordance with Section 673(2) of the Omnibus
3 Budget Reconciliation Act of 1981, applicable to
4 families of the same size; or
5 (ii) their income, after the deduction of
6 costs incurred for medical care and for other types
7 of remedial care, is equal to or less than 70% in
8 fiscal year 2001, equal to or less than 85% in
9 fiscal year 2002 and until a date to be determined
10 by the Department by rule, and equal to or less
11 than 100% beginning on the date determined by the
12 Department by rule, of the nonfarm income official
13 poverty line, as defined in item (i) of this
14 subparagraph (a).
15 (b) All persons who, excluding any eligibility
16 requirements that are inconsistent with any federal
17 law or federal regulation, as interpreted by the U.S.
18 Department of Health and Human Services, would be
19 determined eligible for such basic maintenance under
20 Article IV by disregarding the maximum earned income
21 permitted by federal law.
22 3. Persons who would otherwise qualify for Aid to the
23 Medically Indigent under Article VII.
24 4. Persons not eligible under any of the preceding
25 paragraphs who fall sick, are injured, or die, not having
26 sufficient money, property or other resources to meet the

1 costs of necessary medical care or funeral and burial
2 expenses.
3 5.(a) Women during pregnancy, after the fact of
4 pregnancy has been determined by medical diagnosis, and
5 during the 60-day period beginning on the last day of the
6 pregnancy, together with their infants and children born
7 after September 30, 1983, whose income and resources are
8 insufficient to meet the costs of necessary medical care to
9 the maximum extent possible under Title XIX of the Federal
10 Social Security Act.
11 (b) The Illinois Department and the Governor shall
12 provide a plan for coverage of the persons eligible under
13 paragraph 5(a) by April 1, 1990. Such plan shall provide
14 ambulatory prenatal care to pregnant women during a
15 presumptive eligibility period and establish an income
16 eligibility standard that is equal to 133% of the nonfarm
17 income official poverty line, as defined by the federal
18 Office of Management and Budget and revised annually in
19 accordance with Section 673(2) of the Omnibus Budget
20 Reconciliation Act of 1981, applicable to families of the
21 same size, provided that costs incurred for medical care
22 are not taken into account in determining such income
23 eligibility.
24 (c) The Illinois Department may conduct a
25 demonstration in at least one county that will provide
26 medical assistance to pregnant women, together with their

1 infants and children up to one year of age, where the
2 income eligibility standard is set up to 185% of the
3 nonfarm income official poverty line, as defined by the
4 federal Office of Management and Budget. The Illinois
5 Department shall seek and obtain necessary authorization
6 provided under federal law to implement such a
7 demonstration. Such demonstration may establish resource
8 standards that are not more restrictive than those
9 established under Article IV of this Code.

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

15 7. (Blank).

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

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

1 (b) offer persons who have initially received 6
2 months of the coverage provided in paragraph (a) above,
3 the option of receiving an additional 6 months of
4 coverage, subject to the following:
5 (i) such coverage shall be pursuant to
6 provisions of the federal Social Security Act;
7 (ii) such coverage shall include all services
8 covered while the person was eligible for basic
9 maintenance assistance;
10 (iii) no premium shall be charged for such
11 coverage; and
12 (iv) such coverage shall be suspended in the
13 event of a person's failure without good cause to
14 file in a timely fashion reports required for this
15 coverage under the Social Security Act and
16 coverage shall be reinstated upon the filing of
17 such reports if the person remains otherwise
18 eligible.
19 9. Persons with acquired immunodeficiency syndrome
20 (AIDS) or with AIDS-related conditions with respect to whom
21 there has been a determination that but for home or
22 community-based services such individuals would require
23 the level of care provided in an inpatient hospital,
24 skilled nursing facility or intermediate care facility the
25 cost of which is reimbursed under this Article. Assistance
26 shall be provided to such persons to the maximum extent

permitted under Title XIX of the Federal Social Security Act.

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

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

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

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

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

1 (d) continue to apply subparagraphs (b) and (c) in
2 determining the eligibility of the person under this
3 Article even if the person loses eligibility under this
4 paragraph 11.
5 12. Subject to federal approval, persons who are
6 eligible for medical assistance coverage under applicable
7 provisions of the federal Social Security Act and the
8 federal Breast and Cervical Cancer Prevention and
9 Treatment Act of 2000. Those eligible persons are defined
10 to include, but not be limited to, the following persons:
11 (1) persons who have been screened for breast or
12 cervical cancer under the U.S. Centers for Disease
13 Control and Prevention Breast and Cervical Cancer
14 Program established under Title XV of the federal
15 Public Health Services Act in accordance with the
16 requirements of Section 1504 of that Act as
17 administered by the Illinois Department of Public
18 Health; and
19 (2) persons whose screenings under the above
20 program were funded in whole or in part by funds
21 appropriated to the Illinois Department of Public
22 Health for breast or cervical cancer screening.
23 "Medical assistance" under this paragraph 12 shall be
24 identical to the benefits provided under the State's
25 approved plan under Title XIX of the Social Security Act.
26 The Department must request federal approval of the

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

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened for breast and cervical cancer in accordance with standards and procedures adopted by the Department of Public Health for screening, and who is referred to the Department by the Department of Public Health as being in need of treatment for breast or cervical cancer is eligible for medical assistance benefits that are consistent with the benefits provided to those persons described in subparagraphs (1) and (2). Medical assistance coverage for the persons who are eligible under the preceding sentence is not dependent on federal approval, but federal moneys may be used to pay for services provided under that coverage upon federal approval.

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

1 14. Subject to the availability of funds for this
2 purpose, the Department may provide coverage under this
3 Article to persons who reside in Illinois who are not
4 eligible under any of the preceding paragraphs and who meet
5 the income guidelines of paragraph 2(a) of this Section and
6 (i) have an application for asylum pending before the
7 federal Department of Homeland Security or on appeal before
8 a court of competent jurisdiction and are represented
9 either by counsel or by an advocate accredited by the
10 federal Department of Homeland Security and employed by a
11 not-for-profit organization in regard to that application
12 or appeal, or (ii) are receiving services through a
13 federally funded torture treatment center. Medical
14 coverage under this paragraph 14 may be provided for up to
15 24 continuous months from the initial eligibility date so
16 long as an individual continues to satisfy the criteria of
17 this paragraph 14. If an individual has an appeal pending
18 regarding an application for asylum before the Department
19 of Homeland Security, eligibility under this paragraph 14
20 may be extended until a final decision is rendered on the
21 appeal. The Department may adopt rules governing the
22 implementation of this paragraph 14.
23 15. Family Care Eligibility.
24 (a) On and after July 1, 2012, a caretaker relative
25 who is 19 years of age or older when countable income
26 is at or below 133% of the Federal Poverty Level

1 Guidelines, as published annually in the Federal
2 Register, for the appropriate family size. A person may
3 not spend down to become eligible under this paragraph
4 15.
5 (b) Eligibility shall be reviewed annually.
6 (c) (Blank).
7 (d) (Blank).
8 (e) (Blank).
9 (f) (Blank).
10 (g) (Blank).
11 (h) (Blank).
12 (i) Following termination of an individual's
13 coverage under this paragraph 15, the individual must
14 be determined eligible before the person can be
15 re-enrolled.
16 16. Subject to appropriation, uninsured persons who
17 are not otherwise eligible under this Section who have been
18 certified and referred by the Department of Public Health
19 as having been screened and found to need diagnostic
20 evaluation or treatment, or both diagnostic evaluation and
21 treatment, for prostate or testicular cancer. For the
22 purposes of this paragraph 16, uninsured persons are those
23 who do not have creditable coverage, as defined under the
24 Health Insurance Portability and Accountability Act, or
25 have otherwise exhausted any insurance benefits they may
26 have had, for prostate or testicular cancer diagnostic

1 evaluation or treatment, or both diagnostic evaluation and
2 treatment. To be eligible, a person must furnish a Social
3 Security number. A person's assets are exempt from
4 consideration in determining eligibility under this
5 paragraph 16. Such persons shall be eligible for medical
6 assistance under this paragraph 16 for so long as they need
7 treatment for the cancer. A person shall be considered to
8 need treatment if, in the opinion of the person's treating
9 physician, the person requires therapy directed toward
10 cure or palliation of prostate or testicular cancer,
11 including recurrent metastatic cancer that is a known or
12 presumed complication of prostate or testicular cancer and
13 complications resulting from the treatment modalities
14 themselves. Persons who require only routine monitoring
15 services are not considered to need treatment. "Medical
16 assistance" under this paragraph 16 shall be identical to
17 the benefits provided under the State's approved plan under
18 Title XIX of the Social Security Act. Notwithstanding any
19 other provision of law, the Department (i) does not have a
20 claim against the estate of a deceased recipient of
21 services under this paragraph 16 and (ii) does not have a
22 lien against any homestead property or other legal or
23 equitable real property interest owned by a recipient of
24 services under this paragraph 16.
25 17. Persons who, pursuant to a waiver approved by the
26 Secretary of the U.S. Department of Health and Human

1 Services, are eligible for medical assistance under Title
2 XIX or XXI of the federal Social Security Act.
3 Notwithstanding any other provision of this Code and
4 consistent with the terms of the approved waiver, the
5 Illinois Department, may by rule:
6 (a) Limit the geographic areas in which the waiver
7 program operates.
8 (b) Determine the scope, quantity, duration, and
9 quality, and the rate and method of reimbursement, of
10 the medical services to be provided, which may differ
11 from those for other classes of persons eligible for
12 assistance under this Article.
13 (c) Restrict the persons' freedom in choice of
14 providers.
15 18. Beginning January 1, 2014, persons aged 19 or
16 older, but younger than 65, who are not otherwise eligible
17 for medical assistance under this Section 5-2, who qualify
18 for medical assistance pursuant to 42 U.S.C.
19 1396a(a)(10)(A)(i)(VIII) and as set forth in 42 CFR
20 435.119, and who have income at or below 133% of the
21 federal poverty level plus 5% for the applicable family
22 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and
23 as set forth in 42 CFR 435.603. Persons eligible for
24 medical assistance under this paragraph 18 shall receive
25 coverage for the Health Benefits Service Package as that
26 term is defined in subsection (m) of Section 5-1.1 of this

Code. If Illinois' federal medical assistance percentage (FMAP) is reduced below 90% for persons eligible for medical assistance under this paragraph 18, eligibility under this paragraph 18 shall cease no later than the end of the third month following the month in which the reduction in FMAP takes effect.

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

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

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall

at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

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

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

Notwithstanding any other provision of this Code, if the United States Supreme Court holds Title II, Subtitle A, Section 2001(a) of Public Law 111-148 to be unconstitutional, or if a holding of Public Law 111-148 makes Medicaid eligibility allowed under Section 2001(a) inoperable, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after the effective date of this amendatory Act of the 97th General Assembly, and any individuals enrolled in the Medical

1 Assistance Program pursuant to eligibility permitted as a
2 result of such a State Medicaid waiver shall become immediately
3 ineligible.

4 Notwithstanding any other provision of this Code, if an Act
5 of Congress that becomes a Public Law eliminates Section
6 2001(a) of Public Law 111-148, the State or a unit of local
7 government shall be prohibited from enrolling individuals in
8 the Medical Assistance Program as the result of federal
9 approval of a State Medicaid waiver on or after the effective
10 date of this amendatory Act of the 97th General Assembly, and
11 any individuals enrolled in the Medical Assistance Program
12 pursuant to eligibility permitted as a result of such a State
13 Medicaid waiver shall become immediately ineligible.
14 (Source: P.A. 96-20, eff. 6-30-09; 96-181, eff. 8-10-09;
15 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff.
16 7-2-10; 96-1123, eff. 1-1-11; 96-1270, eff. 7-26-10; 97-48,
17 eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11;
18 97-687, eff. 6-14-12; 97-689, eff. 6-14-12; 97-813, eff.
19 7-13-12; revised 7-23-12.)

20 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)
21 (Section scheduled to be repealed on January 1, 2015)
22 Sec. 5A-2. Assessment.
23 (a) Subject to Sections 5A-3 and 5A-10, for State fiscal
24 years 2009 through 2014, and from July 1, 2014 through December
25 31, 2014, an annual assessment on inpatient services is imposed

on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days.

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

(b) (Blank).

(b-5) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2014, and July 1, 2014 through December 31, 2014, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue. For the period beginning June 10, 2012 through

1 June 30, 2012, the annual assessment on outpatient services
2 shall be prorated by multiplying the assessment amount by a
3 fraction, the numerator of which is 21 days and the denominator
4 of which is 365 days.
5 For the portion of State fiscal year 2012, beginning June
6 10, 2012 through June 30, 2012, and State fiscal years 2013
7 through 2014, and July 1, 2014 through December 31, 2014, a
8 hospital's outpatient gross revenue shall be determined using
9 the most recent data available from each hospital's 2009
10 Medicare cost report as contained in the Healthcare Cost Report
11 Information System file, for the quarter ending on June 30,
12 2011, without regard to any subsequent adjustments or changes
13 to such data. If a hospital's 2009 Medicare cost report is not
14 contained in the Healthcare Cost Report Information System,
15 then the Department may obtain the hospital provider's
16 outpatient gross revenue from any source available, including,
17 but not limited to, records maintained by the hospital
18 provider, which may be inspected at all times during business
19 hours of the day by the Department or its duly authorized
20 agents and employees.
21 (c) (Blank).
22 (d) Notwithstanding any of the other provisions of this
23 Section, the Department is authorized to adopt rules to reduce
24 the rate of any annual assessment imposed under this Section,
25 as authorized by Section 5-46.2 of the Illinois Administrative
26 Procedure Act.

1 (e) Notwithstanding any other provision of this Section,
2 any plan providing for an assessment on a hospital provider as
3 a permissible tax under Title XIX of the federal Social
4 Security Act and Medicaid-eligible payments to hospital
5 providers from the revenues derived from that assessment shall
6 be reviewed by the Illinois Department of Healthcare and Family
7 Services, as the Single State Medicaid Agency required by
8 federal law, to determine whether those assessments and
9 hospital provider payments meet federal Medicaid standards. If
10 the Department determines that the elements of the plan may
11 meet federal Medicaid standards and a related State Medicaid
12 Plan Amendment is prepared in a manner and form suitable for
13 submission, that State Plan Amendment shall be submitted in a
14 timely manner for review by the Centers for Medicare and
15 Medicaid Services of the United States Department of Health and
16 Human Services and subject to approval by the Centers for
17 Medicare and Medicaid Services of the United States Department
18 of Health and Human Services. No such plan shall become
19 effective without approval by the Illinois General Assembly by
20 the enactment into law of related legislation. Notwithstanding
21 any other provision of this Section, the Department is
22 authorized to adopt rules to reduce the rate of any annual
23 assessment imposed under this Section. Any such rules may be
24 adopted by the Department under Section 5-50 of the Illinois
25 Administrative Procedure Act.
26 (Source: P.A. 96-1530, eff. 2-16-11; 97-688, eff. 6-14-12;

1 97-689, eff. 6-14-12.)

2 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)
3 Sec. 5A-4. Payment of assessment; penalty.
4 (a) The assessment imposed by Section 5A-2 for State fiscal
5 year 2009 and each subsequent State fiscal year shall be due
6 and payable in monthly installments, each equaling one-twelfth
7 of the assessment for the year, on the fourteenth State
8 business day of each month. No installment payment of an
9 assessment imposed by Section 5A-2 shall be due and payable,
10 however, until after the Comptroller has issued the payments
11 required under this Article.
12 Except as provided in subsection (a-5) of this Section, the
13 assessment imposed by subsection (b-5) of Section 5A-2 for the
14 portion of State fiscal year 2012 beginning June 10, 2012
15 through June 30, 2012, and for State fiscal year 2013 and each
16 subsequent State fiscal year shall be due and payable in
17 monthly installments, each equaling one-twelfth of the
18 assessment for the year, on the 14th State business day of each
19 month. No installment payment of an assessment imposed by
20 subsection (b-5) of Section 5A-2 shall be due and payable,
21 however, until after: (i) the Department notifies the hospital
22 provider, in writing, that the payment methodologies to
23 hospitals required under Section 5A-12.4, have been approved by
24 the Centers for Medicare and Medicaid Services of the U.S.
25 Department of Health and Human Services, and the waiver under

42 CFR 433.68 for the assessment imposed by subsection (b-5) of Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12.4. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.4 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b-5) of Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.4.

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

(b) The Illinois Department is authorized to establish

delayed payment schedules for hospital providers that are unable to make installment payments when due under this Section due to financial difficulties, as determined by the Illinois Department.

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

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

(Source: P.A. 96-821, eff. 11-20-09; 97-688, eff. 6-14-12; 97-689, eff. 6-14-12.)

1 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)
2 Sec. 5A-5. Notice; penalty; maintenance of records.
3 (a) The Illinois Department shall send a notice of
4 assessment to every hospital provider subject to assessment
5 under this Article. The notice of assessment shall notify the
6 hospital of its assessment and shall be sent after receipt by
7 the Department of notification from the Centers for Medicare
8 and Medicaid Services of the U.S. Department of Health and
9 Human Services that the payment methodologies required under
10 this Article and, if necessary, the waiver granted under 42 CFR
11 433.68 have been approved. The notice shall be on a form
12 prepared by the Illinois Department and shall state the
13 following:
14 (1) The name of the hospital provider.
15 (2) The address of the hospital provider's principal
16 place of business from which the provider engages in the
17 occupation of hospital provider in this State, and the name
18 and address of each hospital operated, conducted, or
19 maintained by the provider in this State.
20 (3) The occupied bed days, occupied bed days less
21 Medicare days, adjusted gross hospital revenue, or
22 outpatient gross revenue of the hospital provider
23 (whichever is applicable), the amount of assessment
24 imposed under Section 5A-2 for the State fiscal year for
25 which the notice is sent, and the amount of each

1 installment to be paid during the State fiscal year.
2 (4) (Blank).
3 (5) Other reasonable information as determined by the
4 Illinois Department.
5 (b) If a hospital provider conducts, operates, or maintains
6 more than one hospital licensed by the Illinois Department of
7 Public Health, the provider shall pay the assessment for each
8 hospital separately.
9 (c) Notwithstanding any other provision in this Article, in
10 the case of a person who ceases to conduct, operate, or
11 maintain a hospital in respect of which the person is subject
12 to assessment under this Article as a hospital provider, the
13 assessment for the State fiscal year in which the cessation
14 occurs shall be adjusted by multiplying the assessment computed
15 under Section 5A-2 by a fraction, the numerator of which is the
16 number of days in the year during which the provider conducts,
17 operates, or maintains the hospital and the denominator of
18 which is 365. Immediately upon ceasing to conduct, operate, or
19 maintain a hospital, the person shall pay the assessment for
20 the year as so adjusted (to the extent not previously paid).
21 (d) Notwithstanding any other provision in this Article, a
22 provider who commences conducting, operating, or maintaining a
23 hospital, upon notice by the Illinois Department, shall pay the
24 assessment computed under Section 5A-2 and subsection (e) in
25 installments on the due dates stated in the notice and on the
26 regular installment due dates for the State fiscal year

1 occurring after the due dates of the initial notice.
2 (e) Notwithstanding any other provision in this Article,
3 for State fiscal years 2009 through 2015, in the case of a
4 hospital provider that did not conduct, operate, or maintain a
5 hospital in 2005, the assessment for that State fiscal year
6 shall be computed on the basis of hypothetical occupied bed
7 days for the full calendar year as determined by the Illinois
8 Department. Notwithstanding any other provision in this
9 Article, for the portion of State fiscal year 2012 beginning
10 June 10, 2012 through June 30, 2012, and for State fiscal years
11 2013 through 2014, and for July 1, 2014 through December 31,
12 2014, in the case of a hospital provider that did not conduct,
13 operate, or maintain a hospital in 2009, the assessment under
14 subsection (b-5) of Section 5A-2 for that State fiscal year
15 shall be computed on the basis of hypothetical gross outpatient
16 revenue for the full calendar year as determined by the
17 Illinois Department.
18 (f) Every hospital provider subject to assessment under
19 this Article shall keep sufficient records to permit the
20 determination of adjusted gross hospital revenue for the
21 hospital's fiscal year. All such records shall be kept in the
22 English language and shall, at all times during regular
23 business hours of the day, be subject to inspection by the
24 Illinois Department or its duly authorized agents and
25 employees.
26 (g) The Illinois Department may, by rule, provide a

hospital provider a reasonable opportunity to request a clarification or correction of any clerical or computational errors contained in the calculation of its assessment, but such corrections shall not extend to updating the cost report information used to calculate the assessment.

(h) (Blank).

(Source: P.A. 96-1530, eff. 2-16-11; 97-688, eff. 6-14-12; 97-689, eff. 6-14-12; revised 10-17-12.)

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

Sec. 5A-8. Hospital Provider Fund.

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

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

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

(2) For the reimbursement of moneys collected by the Illinois Department from hospitals or hospital providers

1 through error or mistake in performing the activities
2 authorized under this Code.
3 (3) For payment of administrative expenses incurred by
4 the Illinois Department or its agent in performing
5 activities under this Code, under the Children's Health
6 Insurance Program Act, under the Covering ALL KIDS Health
7 Insurance Act, and under the Long Term Acute Care Hospital
8 Quality Improvement Transfer Program Act.
9 (4) For payments of any amounts which are reimbursable
10 to the federal government for payments from this Fund which
11 are required to be paid by State warrant.
12 (5) For making transfers, as those transfers are
13 authorized in the proceedings authorizing debt under the
14 Short Term Borrowing Act, but transfers made under this
15 paragraph (5) shall not exceed the principal amount of debt
16 issued in anticipation of the receipt by the State of
17 moneys to be deposited into the Fund.
18 (6) For making transfers to any other fund in the State
19 treasury, but transfers made under this paragraph (6) shall
20 not exceed the amount transferred previously from that
21 other fund into the Hospital Provider Fund plus any
22 interest that would have been earned by that fund on the
23 monies that had been transferred.
24 (6.5) For making transfers to the Healthcare Provider
25 Relief Fund, except that transfers made under this
26 paragraph (6.5) shall not exceed $60,000,000 in the

aggregate.

(7) For making transfers not exceeding the following amounts, in State fiscal years 2013 and 2014 in each State fiscal year during which an assessment is imposed pursuant to Section 5A-2, to the following designated funds:

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

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

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

(7.1) For making transfers not exceeding the following amounts, in State fiscal year 2015, to the following designated funds:

Health and Human Services Medicaid Trust Fund........................... $10,000,000

Long-Term Care Provider Fund $15,000,000

General Revenue Fund .... $40,000,000.

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

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

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

Health Care Provider Relief Fund $50,000,000

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

(7.11) For State fiscal year 2015, for making transfers of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health Care Provider Relief Fund $25,000,000

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

(7.12) For State fiscal year 2013, for increasing by

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

Health Care Provider Relief Fund $2,870,000

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

(d) (Blank).

(Source: P.A. 96-3, eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09; 96-1530, eff. 2-16-11; 97-688, eff. 6-14-12; 97-689, eff. 6-14-12; revised 10-17-12.)

(305 ILCS 5/5A-12.4)

(Section scheduled to be repealed on January 1, 2015)

Sec. 5A-12.4. Hospital access improvement payments on or after June 10, 2012 ~~July 1, 2012~~.

(a) Hospital access improvement payments. To preserve and improve access to hospital services, for hospital and physician services rendered on or after June 10, 2012 ~~July 1, 2012~~, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the 7th State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section

are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under subsection (b-5) of Section 5A-2 of this Article is determined to be a permissible tax under Title XIX of the Social Security Act. The Illinois Department shall take all actions necessary to implement the payments under this Section effective June 10, 2012 ~~July 1, 2012~~, including but not limited to providing public notice pursuant to federal requirements, the filing of a State Plan amendment, and the adoption of administrative rules. For State fiscal year 2013, payments under this Section shall be increased by 21/365ths. The funding source for these additional payments shall be from the increased assessment under subsection (b-5) of Section 5A-2 that was received from hospital providers under Section 5A-4 for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012.

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

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

amounts as follows:

(1) For hospitals with a case mix index equal to or greater than the 80th percentile of case mix indices for all Illinois hospitals, $470 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

(2) For all other hospitals, $170 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

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

(1) For hospitals with a case mix index equal to or greater than the 50th percentile of case mix indices for all Illinois hospitals, $470 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

(2) For all other hospitals, $170 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

(3) For the purposes of this adjustment, hospitals located in the same city that alternate their trauma center designation as defined in 89 Ill. Adm. Code 148.295(a)(2) shall have the adjustment provided under this Section

1 divided between the 2 hospitals.
2 (d) Dual-eligible adjustment. In addition to rates paid for
3 inpatient services, the Department shall pay each Illinois
4 general acute care hospital that had a ratio of crossover days
5 to total inpatient days for programs under Title XIX of the
6 Social Security Act administered by the Department (utilizing
7 information from 2009 paid claims) greater than 50%, and a case
8 mix index equal to or greater than the 75th percentile of case
9 mix indices for all Illinois hospitals, a rate of $400 for each
10 Medicaid inpatient day during State fiscal year 2009 including
11 crossover days.
12 (e) Medicaid volume adjustment. In addition to rates paid
13 for inpatient hospital services, the Department shall pay to
14 each Illinois general acute care hospital that provided more
15 than 10,000 Medicaid inpatient days of care in State fiscal
16 year 2009, has a Medicaid inpatient utilization rate of at
17 least 29.05% as calculated by the Department for the Rate Year
18 2011 Disproportionate Share determination, and is not eligible
19 for Medicaid Percentage Adjustment payments in rate year 2011
20 an amount equal to $135 for each Medicaid inpatient day of care
21 provided during State fiscal year 2009.
22 (f) Outpatient service adjustment. In addition to the rates
23 paid for outpatient hospital services, the Department shall pay
24 each Illinois hospital an amount at least equal to $100
25 multiplied by the hospital's outpatient ambulatory procedure
26 listing services (excluding categories 3B and 3C) and by the

hospital's end stage renal disease treatment services provided for State fiscal year 2009.

(g) Ambulatory service adjustment.

(1) In addition to the rates paid for outpatient hospital services provided in the emergency department, the Department shall pay each Illinois hospital an amount equal to $105 multiplied by the hospital's outpatient ambulatory procedure listing services for categories 3A, 3B, and 3C for State fiscal year 2009.

(2) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding psychiatric hospital an amount equal to $200 multiplied by the hospital's ambulatory procedure listing services for category 5A for State fiscal year 2009.

(h) Specialty hospital adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois long term acute care hospital and each Illinois hospital devoted exclusively to the treatment of cancer, an amount equal to $700 multiplied by the hospital's outpatient ambulatory procedure listing services and by the hospital's end stage renal disease treatment services (including services provided to individuals eligible for both Medicaid and Medicare) provided for State fiscal year 2009.

(h-1) ER Safety Net Payments. In addition to rates paid for outpatient services, the Department shall pay to each Illinois general acute care hospital with an emergency room ratio equal

1 to or greater than 55%, that is not eligible for Medicaid
2 percentage adjustments payments in rate year 2011, with a case
3 mix index equal to or greater than the 20th percentile, and
4 that is not designated as a trauma center by the Illinois
5 Department of Public Health on July 1, 2011, as follows:
6 (1) Each hospital with an emergency room ratio equal to
7 or greater than 74% shall receive a rate of $225 for each
8 outpatient ambulatory procedure listing and end-stage
9 renal disease treatment service provided for State fiscal
10 year 2009.
11 (2) For all other hospitals, $65 shall be paid for each
12 outpatient ambulatory procedure listing and end-stage
13 renal disease treatment service provided for State fiscal
14 year 2009.
15 (i) Physician supplemental adjustment. In addition to the
16 rates paid for physician services, the Department shall make an
17 adjustment payment for services provided by physicians as
18 follows:
19 (1) Physician services eligible for the adjustment
20 payment are those provided by physicians employed by or who
21 have a contract to provide services to patients of the
22 following hospitals: (i) Illinois general acute care
23 hospitals that provided at least 17,000 Medicaid inpatient
24 days of care in State fiscal year 2009 and are eligible for
25 Medicaid Percentage Adjustment Payments in rate year 2011;
26 and (ii) Illinois freestanding children's hospitals, as

1 defined in 89 Ill. Adm. Code 149.50(c)(3)(A).
2 (2) The amount of the adjustment for each eligible
3 hospital under this subsection (i) shall be determined by
4 rule by the Department to spend a total pool of at least
5 $6,960,000 annually. This pool shall be allocated among the
6 eligible hospitals based on the difference between the
7 upper payment limit for what could have been paid under
8 Medicaid for physician services provided during State
9 fiscal year 2009 by physicians employed by or who had a
10 contract with the hospital and the amount that was paid
11 under Medicaid for such services, provided however, that in
12 no event shall physicians at any individual hospital
13 collectively receive an annual, aggregate adjustment in
14 excess of $435,000, except that any amount that is not
15 distributed to a hospital because of the upper payment
16 limit shall be reallocated among the remaining eligible
17 hospitals that are below the upper payment limitation, on a
18 proportionate basis.
19 (i-5) For any children's hospital which did not charge for
20 its services during the base period, the Department shall use
21 data supplied by the hospital to determine payments using
22 similar methodologies for freestanding children's hospitals
23 under this Section or Section 5A-12.2 ~~12.2~~.
24 (j) For purposes of this Section, a hospital that is
25 enrolled to provide Medicaid services during State fiscal year
26 2009 shall have its utilization and associated reimbursements

1 annualized prior to the payment calculations being performed
2 under this Section.
3 (k) For purposes of this Section, the terms "Medicaid
4 days", "ambulatory procedure listing services", and
5 "ambulatory procedure listing payments" do not include any
6 days, charges, or services for which Medicare or a managed care
7 organization reimbursed on a capitated basis was liable for
8 payment, except where explicitly stated otherwise in this
9 Section.
10 (l) Definitions. Unless the context requires otherwise or
11 unless provided otherwise in this Section, the terms used in
12 this Section for qualifying criteria and payment calculations
13 shall have the same meanings as those terms have been given in
14 the Illinois Department's administrative rules as in effect on
15 October 1, 2011. Other terms shall be defined by the Illinois
16 Department by rule.
17 As used in this Section, unless the context requires
18 otherwise:
19 "Case mix index" means, for a given hospital, the sum of
20 the per admission (DRG) relative weighting factors in effect on
21 January 1, 2005, for all general acute care admissions for
22 State fiscal year 2009, excluding Medicare crossover
23 admissions and transplant admissions reimbursed under 89 Ill.
24 Adm. Code 148.82, divided by the total number of general acute
25 care admissions for State fiscal year 2009, excluding Medicare
26 crossover admissions and transplant admissions reimbursed

1 under 89 Ill. Adm. Code 148.82.

2 "Emergency room ratio" means, for a given hospital, a
3 fraction, the denominator of which is the number of the
4 hospital's outpatient ambulatory procedure listing and
5 end-stage renal disease treatment services provided for State
6 fiscal year 2009 and the numerator of which is the hospital's
7 outpatient ambulatory procedure listing services for
8 categories 3A, 3B, and 3C for State fiscal year 2009.

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

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

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

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

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

(o) The Department of Healthcare and Family Services must submit a State Medicaid Plan Amendment to the Centers of

1 Medicare and Medicaid Services to implement the payments under
2 this Section. ~~within 30 days of the effective date of this Act.~~
3 (Source: P.A. 97-688, eff. 6-14-12; revised 8-3-12.)

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