

1 AN ACT concerning State government.

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

4 Section 5. The Illinois Administrative Procedure Act is
5 amended by changing Section 5-50 as follows:

6 (5 ILCS 100/5-50) (from Ch. 127, par. 1005-50)

7 Sec. 5-50. Peremptory rulemaking. "Peremptory rulemaking"
8 means any rulemaking that is required as a result of federal
9 law, federal rules and regulations, an order of a court, or a
10 collective bargaining agreement pursuant to subsection (d) of
11 Section 1-5, under conditions that preclude compliance with the
12 general rulemaking requirements imposed by Section 5-40 and
13 that preclude the exercise of discretion by the agency as to
14 the content of the rule it is required to adopt. Peremptory
15 rulemaking shall not be used to implement consent orders or
16 other court orders adopting settlements negotiated by the
17 agency. If any agency finds that peremptory rulemaking is
18 necessary and states in writing its reasons for that finding,
19 the agency may adopt peremptory rulemaking upon filing a notice
20 of rulemaking with the Secretary of State under Section 5-70.
21 The notice shall be published in the Illinois Register. A rule
22 adopted under the peremptory rulemaking provisions of this
23 Section becomes effective immediately upon filing with the

1 Secretary of State and in the agency's principal office, or at
2 a date required or authorized by the relevant federal law,
3 federal rules and regulations, or court order, as stated in the
4 notice of rulemaking. Notice of rulemaking under this Section
5 shall be published in the Illinois Register, shall specifically
6 refer to the appropriate State or federal court order or
7 federal law, rules, and regulations, and shall be in a form as
8 the Secretary of State may reasonably prescribe by rule. The
9 agency shall file the notice of peremptory rulemaking within 30
10 days after a change in rules is required.

11 The Department of Healthcare and Family Services may adopt
12 peremptory rulemaking under the terms and conditions of this
13 Section to implement final payments included in a State
14 Medicaid Plan Amendment approved by the Centers for Medicare
15 and Medicaid Services of the United States Department of Health
16 and Human Services and authorized under Section 5A-12.2 of the
17 Illinois Public Aid Code, and to adjust hospital provider
18 assessments as Medicaid Provider-Specific Taxes permitted by
19 Title XIX of the federal Social Security Act and authorized
20 under Section 5A-2 of the Illinois Public Aid Code.

21 (Source: P.A. 87-823; 88-667, eff. 9-16-94.)

22 (30 ILCS 105/5.620 rep.)

23 (30 ILCS 105/6z-56 rep.)

24 Section 10. The State Finance Act is amended by repealing
25 Sections 5.620 and 6z-56.

1 Section 15. The Illinois Public Aid Code is amended by
2 changing Sections 5A-1, 5A-2, 5A-3, 5A-4, 5A-5, 5A-8, 5A-10,
3 5A-14, 15-2, 15-3, 15-5, and 15-8 and by adding Sections
4 5A-12.2, 15-10, and 15-11 as follows:

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

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

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

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

12 "Fund" means the Hospital Provider Fund.

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

18 "Hospital provider" means a person licensed by the
19 Department of Public Health to conduct, operate, or maintain a
20 hospital, regardless of whether the person is a Medicaid
21 provider. For purposes of this paragraph, "person" means any
22 political subdivision of the State, municipal corporation,
23 individual, firm, partnership, corporation, company, limited
24 liability company, association, joint stock association, or
25 trust, or a receiver, executor, trustee, guardian, or other
26 representative appointed by order of any court.

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

8 "Occupied bed days" means the sum of the number of days
9 that each bed was occupied by a patient for all beds, excluding
10 days attributable to the routine services provided to persons
11 receiving skilled or intermediate long term care services
12 ~~during calendar year 2001~~. Occupied bed days shall be computed
13 separately for each hospital operated or maintained by a
14 hospital provider.

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

17 (Source: P.A. 93-659, eff. 2-3-04; 93-1066, eff. 1-15-05;
18 94-242, eff. 7-18-05.)

19 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

20 (Section scheduled to be repealed on July 1, 2008)

21 Sec. 5A-2. Assessment; ~~no local authorization to tax.~~

22 (a) Subject to Sections 5A-3 and 5A-10, an annual
23 assessment on inpatient services is imposed on each hospital
24 provider in an amount equal to the hospital's occupied bed days
25 multiplied by \$84.19 multiplied by the proration factor for

1 State fiscal year 2004 and the hospital's occupied bed days
2 multiplied by \$84.19 for State fiscal year 2005.

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

19 Subject to Sections 5A-3 and 5A-10, for the privilege of
20 engaging in the occupation of hospital provider, beginning
21 August 1, 2005, an annual assessment is imposed on each
22 hospital provider for State fiscal years 2006, 2007, and 2008,
23 in an amount equal to 2.5835% of the hospital provider's
24 adjusted gross hospital revenue for inpatient services and
25 2.5835% of the hospital provider's adjusted gross hospital
26 revenue for outpatient services. If the hospital provider's

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

8 Subject to Sections 5A-3 and 5A-10, for State fiscal years
9 2009 through 2013, an annual assessment on inpatient services
10 is imposed on each hospital provider in an amount equal to
11 \$218.38 multiplied by the difference of the hospital's occupied
12 bed days less the hospital's Medicare bed days.

13 For State fiscal years 2009 through 2013, a hospital's
14 occupied bed days and Medicare bed days shall be determined
15 using the most recent data available from each hospital's 2005
16 Medicare cost report as contained in the Healthcare Cost Report
17 Information System file, for the quarter ending on December 31,
18 2006, without regard to any subsequent adjustments or changes
19 to such data. If a hospital's 2005 Medicare cost report is not
20 contained in the Healthcare Cost Report Information System,
21 then the Illinois Department may obtain the hospital provider's
22 occupied bed days and Medicare bed days from any source
23 available, including, but not limited to, records maintained by
24 the hospital provider, which may be inspected at all times
25 during business hours of the day by the Illinois Department or
26 its duly authorized agents and employees.

1 (b) (Blank). ~~Nothing in this Article shall be construed to~~
2 ~~authorize any home rule unit or other unit of local government~~
3 ~~to license for revenue or to impose a tax or assessment upon~~
4 ~~hospital providers or the occupation of hospital provider, or a~~
5 ~~tax or assessment measured by the income or earnings of a~~
6 ~~hospital provider.~~

7 (c) (Blank). ~~As provided in Section 5A-14, this Section is~~
8 ~~repealed on July 1, 2008.~~

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

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

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

13 (Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04;
14 93-1066, eff. 1-15-05; 94-242, eff. 7-18-05; 94-838, eff.
15 6-6-06.)

16 (305 ILCS 5/5A-3) (from Ch. 23, par. 5A-3)

17 Sec. 5A-3. Exemptions.

18 (a) (Blank).

19 (b) A hospital provider that is a State agency, a State
20 university, or a county with a population of 3,000,000 or more
21 is exempt from the assessment imposed by Section 5A-2.

22 (b-2) A hospital provider that is a county with a
23 population of less than 3,000,000 or a township, municipality,
24 hospital district, or any other local governmental unit is
25 exempt from the assessment imposed by Section 5A-2.

1 (b-5) (Blank).

2 (b-10) For State fiscal years 2004 through 2013 ~~and 2005~~, a
3 hospital provider, described in Section 1903(w)(3)(F) of the
4 Social Security Act, whose hospital does not charge for its
5 services is exempt from the assessment imposed by Section 5A-2,
6 unless the exemption is adjudged to be unconstitutional or
7 otherwise invalid, in which case the hospital provider shall
8 pay the assessment imposed by Section 5A-2.

9 (b-15) For State fiscal years 2004 and 2005, a hospital
10 provider whose hospital is licensed by the Department of Public
11 Health as a psychiatric hospital is exempt from the assessment
12 imposed by Section 5A-2, unless the exemption is adjudged to be
13 unconstitutional or otherwise invalid, in which case the
14 hospital provider shall pay the assessment imposed by Section
15 5A-2.

16 (b-20) For State fiscal years 2004 and 2005, a hospital
17 provider whose hospital is licensed by the Department of Public
18 Health as a rehabilitation hospital is exempt from the
19 assessment imposed by Section 5A-2, unless the exemption is
20 adjudged to be unconstitutional or otherwise invalid, in which
21 case the hospital provider shall pay the assessment imposed by
22 Section 5A-2.

23 (b-25) For State fiscal years 2004 and 2005, a hospital
24 provider whose hospital (i) is not a psychiatric hospital,
25 rehabilitation hospital, or children's hospital and (ii) has an
26 average length of inpatient stay greater than 25 days is exempt

1 from the assessment imposed by Section 5A-2, unless the
2 exemption is adjudged to be unconstitutional or otherwise
3 invalid, in which case the hospital provider shall pay the
4 assessment imposed by Section 5A-2.

5 (c) (Blank).

6 (Source: P.A. 93-659, eff. 2-3-04; 94-242, eff. 7-18-05.)

7 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

9 (a) The annual assessment imposed by Section 5A-2 for State
10 fiscal year 2004 shall be due and payable on June 18 of the
11 year. The assessment imposed by Section 5A-2 for State fiscal
12 year 2005 shall be due and payable in quarterly installments,
13 each equalling one-fourth of the assessment for the year, on
14 July 19, October 19, January 18, and April 19 of the year. The
15 assessment imposed by Section 5A-2 for State fiscal years ~~year~~
16 2006 through 2008 ~~and each subsequent State fiscal year~~ shall
17 be due and payable in quarterly installments, each equaling
18 one-fourth of the assessment for the year, on the fourteenth
19 State business day of September, December, March, and May. The
20 assessment imposed by Section 5A-2 for State fiscal year 2009
21 and each subsequent State fiscal year shall be due and payable
22 in monthly installments, each equaling one-twelfth of the
23 assessment for the year, on the fourteenth State business day
24 of each month. No installment payment of an assessment imposed
25 by Section 5A-2 shall be due and payable, however, until after:

1 (i) the Department notifies the hospital provider, in writing,
2 ~~receives written notice from the Department of Healthcare and~~
3 ~~Family Services (formerly Department of Public Aid)~~ that the
4 payment methodologies to hospitals required under Section
5 5A-12, ~~or~~ Section 5A-12.1, or Section 5A-12.2, whichever is
6 applicable for that fiscal year, have been approved by the
7 Centers for Medicare and Medicaid Services of the U.S.
8 Department of Health and Human Services and the waiver under 42
9 CFR 433.68 for the assessment imposed by Section 5A-2, if
10 necessary, has been granted by the Centers for Medicare and
11 Medicaid Services of the U.S. Department of Health and Human
12 Services; and (ii) the Comptroller has issued ~~the hospital has~~
13 ~~received~~ the payments required under Section 5A-12, ~~or~~ Section
14 5A-12.1, or Section 5A-12.2, whichever is applicable for that
15 fiscal year. Upon notification to the Department of approval of
16 the payment methodologies required under Section 5A-12, ~~or~~
17 Section 5A-12.1, or Section 5A-12.2, whichever is applicable
18 for that fiscal year, and the waiver granted under 42 CFR
19 433.68, all ~~quarterly~~ installments otherwise due under Section
20 5A-2 prior to the date of notification shall be due and payable
21 to the Department upon written direction from the Department
22 and issuance by the Comptroller ~~receipt~~ of the payments
23 required under Section 5A-12.1 or Section 5A-12.2, whichever is
24 applicable for that fiscal year.

25 (b) The Illinois Department is authorized to establish
26 delayed payment schedules for hospital providers that are

1 unable to make installment payments when due under this Section
2 due to financial difficulties, as determined by the Illinois
3 Department.

4 (c) If a hospital provider fails to pay the full amount of
5 an installment when due (including any extensions granted under
6 subsection (b)), there shall, unless waived by the Illinois
7 Department for reasonable cause, be added to the assessment
8 imposed by Section 5A-2 a penalty assessment equal to the
9 lesser of (i) 5% of the amount of the installment not paid on
10 or before the due date plus 5% of the portion thereof remaining
11 unpaid on the last day of each 30-day period thereafter or (ii)
12 100% of the installment amount not paid on or before the due
13 date. For purposes of this subsection, payments will be
14 credited first to unpaid installment amounts (rather than to
15 penalty or interest), beginning with the most delinquent
16 installments.

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

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

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

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

2 (a) The Department of Healthcare and Family Services shall
3 send a notice of assessment to every hospital provider subject
4 to assessment under this Article. The notice of assessment
5 shall notify the hospital of its assessment and shall be sent
6 after receipt by the Department of notification from the
7 Centers for Medicare and Medicaid Services of the U.S.
8 Department of Health and Human Services that the payment
9 methodologies required under Section 5A-12, ~~or~~ Section
10 5A-12.1, or Section 5A-12.2, whichever is applicable for that
11 fiscal year, and, if necessary, the waiver granted under 42 CFR
12 433.68 have been approved. The notice shall be on a form
13 prepared by the Illinois Department and shall state the
14 following:

15 (1) The name of the hospital provider.

16 (2) The address of the hospital provider's principal
17 place of business from which the provider engages in the
18 occupation of hospital provider in this State, and the name
19 and address of each hospital operated, conducted, or
20 maintained by the provider in this State.

21 (3) The occupied bed days, occupied bed days less
22 Medicare days, or adjusted gross hospital revenue of the
23 hospital provider (whichever is applicable), the amount of
24 assessment imposed under Section 5A-2 for the State fiscal
25 year for which the notice is sent, and the amount of each
26 ~~quarterly~~ installment to be paid during the State fiscal

1 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 2004 and 2005, in the case of a hospital
4 provider that did not conduct, operate, or maintain a hospital
5 throughout calendar year 2001, the assessment for that State
6 fiscal year shall be computed on the basis of hypothetical
7 occupied bed days for the full calendar year as determined by
8 the Illinois Department. Notwithstanding any other provision
9 in this Article, for State fiscal years 2006 through 2008 ~~after~~
10 ~~2005~~, in the case of a hospital provider that did not conduct,
11 operate, or maintain a hospital in 2003, the assessment for
12 that State fiscal year shall be computed on the basis of
13 hypothetical adjusted gross hospital revenue for the
14 hospital's first full fiscal year as determined by the Illinois
15 Department (which may be based on annualization of the
16 provider's actual revenues for a portion of the year, or
17 revenues of a comparable hospital for the year, including
18 revenues realized by a prior provider of the same hospital
19 during the year). Notwithstanding any other provision in this
20 Article, for State fiscal years 2009 through 2013, in the case
21 of a hospital provider that did not conduct, operate, or
22 maintain a hospital in 2005, the assessment for that State
23 fiscal year shall be computed on the basis of hypothetical
24 occupied bed days for the full calendar year as determined by
25 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. 94-242, eff. 7-18-05; 95-331, eff. 8-21-07.)

16 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

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

1 (1) For making payments to hospitals as required under
2 Articles V, VI, and XIV of this Code, ~~and~~ under the
3 Children's Health Insurance Program Act, and under the
4 Covering ALL KIDS Health Insurance Act.

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

9 (3) For payment of administrative expenses incurred by
10 the Illinois Department or its agent in performing the
11 activities authorized by this Article.

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

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

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

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

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

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

17 Health and Human Services

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

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

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

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

4 Health and Human Services

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

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

12 (7.9) For State fiscal years 2009 through 2013, for
13 making transfers of the moneys received from hospital
14 providers under Section 5A-4 and transferred into the
15 Hospital Provider Fund under Section 5A-6 to the designated
16 funds not exceeding the following amounts in that State
17 fiscal year:

18 Health and Human Services

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

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

26 (8) For making refunds to hospital providers pursuant

1 to Section 5A-10.

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

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

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

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

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

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

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

21 (d) (Blank).

22 (Source: P.A. 94-242, eff. 7-18-05; 94-839, eff. 6-6-06;
23 95-707, eff. 1-11-08.)

24 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)
25 Sec. 5A-10. Applicability.

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

5 (1) The ~~the~~ sum of the appropriations for State fiscal
6 years 2004 and 2005 from the General Revenue Fund for
7 hospital payments under the medical assistance program is
8 less than \$4,500,000,000 or the appropriation for each of
9 State fiscal years 2006, 2007 and 2008 from the General
10 Revenue Fund for hospital payments under the medical
11 assistance program is less than \$2,500,000,000 increased
12 annually to reflect any increase in the number of
13 recipients, or the annual appropriation for State fiscal
14 years 2009 through 2013, from the General Revenue Fund for
15 hospital payments under the medical assistance program, is
16 less than the amount appropriated for State fiscal year
17 2009, adjusted annually to reflect any change in the number
18 of recipients; or

19 (2) For State fiscal years prior to State fiscal year
20 2009, the Department of Healthcare and Family Services
21 (formerly Department of Public Aid) makes changes in its
22 rules that reduce the hospital inpatient or outpatient
23 payment rates, including adjustment payment rates, in
24 effect on October 1, 2004, except for hospitals described
25 in subsection (b) of Section 5A-3 and except for changes in
26 the methodology for calculating outlier payments to

1 hospitals for exceptionally costly stays, so long as those
2 changes do not reduce aggregate expenditures below the
3 amount expended in State fiscal year 2005 for such
4 services; or

5 (2.1) For State fiscal years 2009 through 2013, the
6 Department of Healthcare and Family Services adopts any
7 administrative rule change to reduce payment rates or
8 alters any payment methodology that reduces any payment
9 rates made to operating hospitals under the approved Title
10 XIX or Title XXI State plan in effect January 1, 2008
11 except for:

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

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

16 (C) any changes proposed in State plan amendment
17 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
18 08-07; or

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

23 (b) The assessment imposed by Section 5A-2 shall not take
24 effect or shall cease to be imposed if the assessment is
25 determined to be an impermissible tax under Title XIX of the
26 Social Security Act. Moneys in the Hospital Provider Fund

1 derived from assessments imposed prior thereto shall be
2 disbursed in accordance with Section 5A-8 to the extent federal
3 financial participation ~~matching~~ is not reduced due to the
4 impermissibility of the assessments, and any remaining moneys
5 shall be refunded to hospital providers in proportion to the
6 amounts paid by them.

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

8 (305 ILCS 5/5A-12.2 new)

9 Sec. 5A-12.2. Hospital access payments on or after July 1,
10 2008.

11 (a) To preserve and improve access to hospital services,
12 for hospital services rendered on or after July 1, 2008, the
13 Illinois Department shall, except for hospitals described in
14 subsection (b) of Section 5A-3, make payments to hospitals as
15 set forth in this Section. These payments shall be paid in 12
16 equal installments on or before the seventh State business day
17 of each month, except that no payment shall be due within 100
18 days after the later of the date of notification of federal
19 approval of the payment methodologies required under this
20 Section or any waiver required under 42 CFR 433.68, at which
21 time the sum of amounts required under this Section prior to
22 the date of notification is due and payable. Payments under
23 this Section are not due and payable, however, until (i) the
24 methodologies described in this Section are approved by the
25 federal government in an appropriate State Plan amendment and

1 (ii) the assessment imposed under this Article is determined to
2 be a permissible tax under Title XIX of the Social Security
3 Act.

4 (b) Across-the-board inpatient adjustment.

5 (1) In addition to rates paid for inpatient hospital
6 services, the Department shall pay to each Illinois general
7 acute care hospital an amount equal to 40% of the total
8 base inpatient payments paid to the hospital for services
9 provided in State fiscal year 2005.

10 (2) In addition to rates paid for inpatient hospital
11 services, the Department shall pay to each freestanding
12 Illinois specialty care hospital as defined in 89 Ill. Adm.
13 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
14 the total base inpatient payments paid to the hospital for
15 services provided in State fiscal year 2005.

16 (3) In addition to rates paid for inpatient hospital
17 services, the Department shall pay to each freestanding
18 Illinois rehabilitation or psychiatric hospital an amount
19 equal to \$1,000 per Medicaid inpatient day multiplied by
20 the increase in the hospital's Medicaid inpatient
21 utilization ratio (determined using the positive
22 percentage change from the rate year 2005 Medicaid
23 inpatient utilization ratio to the rate year 2007 Medicaid
24 inpatient utilization ratio, as calculated by the
25 Department for the disproportionate share determination).

26 (4) In addition to rates paid for inpatient hospital

1 services, the Department shall pay to each Illinois
2 children's hospital an amount equal to 20% of the total
3 base inpatient payments paid to the hospital for services
4 provided in State fiscal year 2005 and an additional amount
5 equal to 20% of the base inpatient payments paid to the
6 hospital for psychiatric services provided in State fiscal
7 year 2005.

8 (5) In addition to rates paid for inpatient hospital
9 services, the Department shall pay to each Illinois
10 hospital eligible for a pediatric inpatient adjustment
11 payment under 89 Ill. Adm. Code 148.298, as in effect for
12 State fiscal year 2007, a supplemental pediatric inpatient
13 adjustment payment equal to:

14 (i) For freestanding children's hospitals as
15 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
16 multiplied by the hospital's pediatric inpatient
17 adjustment payment required under 89 Ill. Adm. Code
18 148.298, as in effect for State fiscal year 2008.

19 (ii) For hospitals other than freestanding
20 children's hospitals as defined in 89 Ill. Adm. Code
21 149.50(c)(3)(B), 1.0 multiplied by the hospital's
22 pediatric inpatient adjustment payment required under
23 89 Ill. Adm. Code 148.298, as in effect for State
24 fiscal year 2008.

25 (c) Outpatient adjustment.

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

1 hospital services, the Department shall pay each Illinois
2 hospital an amount equal to 2.2 multiplied by the
3 hospital's ambulatory procedure listing payments for
4 categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code
5 148.140(b), for State fiscal year 2005.

6 (2) In addition to the rates paid for outpatient
7 hospital services, the Department shall pay each Illinois
8 freestanding psychiatric hospital an amount equal to 3.25
9 multiplied by the hospital's ambulatory procedure listing
10 payments for category 5b, as defined in 89 Ill. Adm. Code
11 148.140(b)(1)(E), for State fiscal year 2005.

12 (d) Medicaid high volume adjustment. In addition to rates
13 paid for inpatient hospital services, the Department shall pay
14 to each Illinois general acute care hospital that provided more
15 than 20,500 Medicaid inpatient days of care in State fiscal
16 year 2005 amounts as follows:

17 (1) For hospitals with a case mix index equal to or
18 greater than the 85th percentile of hospital case mix
19 indices, \$350 for each Medicaid inpatient day of care
20 provided during that period; and

21 (2) For hospitals with a case mix index less than the
22 85th percentile of hospital case mix indices, \$100 for each
23 Medicaid inpatient day of care provided during that period.

24 (e) Capital adjustment. In addition to rates paid for
25 inpatient hospital services, the Department shall pay an
26 additional payment to each Illinois general acute care hospital

1 that has a Medicaid inpatient utilization rate of at least 10%
2 (as calculated by the Department for the rate year 2007
3 disproportionate share determination) amounts as follows:

4 (1) For each Illinois general acute care hospital that
5 has a Medicaid inpatient utilization rate of at least 10%
6 and less than 36.94% and whose capital cost is less than
7 the 60th percentile of the capital costs of all Illinois
8 hospitals, the amount of such payment shall equal the
9 hospital's Medicaid inpatient days multiplied by the
10 difference between the capital costs at the 60th percentile
11 of the capital costs of all Illinois hospitals and the
12 hospital's capital costs.

13 (2) For each Illinois general acute care hospital that
14 has a Medicaid inpatient utilization rate of at least
15 36.94% and whose capital cost is less than the 75th
16 percentile of the capital costs of all Illinois hospitals,
17 the amount of such payment shall equal the hospital's
18 Medicaid inpatient days multiplied by the difference
19 between the capital costs at the 75th percentile of the
20 capital costs of all Illinois hospitals and the hospital's
21 capital costs.

22 (f) Obstetrical care adjustment.

23 (1) In addition to rates paid for inpatient hospital
24 services, the Department shall pay \$1,500 for each Medicaid
25 obstetrical day of care provided in State fiscal year 2005
26 by each Illinois rural hospital that had a Medicaid

1 obstetrical percentage (Medicaid obstetrical days divided
2 by Medicaid inpatient days) greater than 15% for State
3 fiscal year 2005.

4 (2) In addition to rates paid for inpatient hospital
5 services, the Department shall pay \$1,350 for each Medicaid
6 obstetrical day of care provided in State fiscal year 2005
7 by each Illinois general acute care hospital that was
8 designated a level III perinatal center as of December 31,
9 2006, and that had a case mix index equal to or greater
10 than the 45th percentile of the case mix indices for all
11 level III perinatal centers.

12 (3) In addition to rates paid for inpatient hospital
13 services, the Department shall pay \$900 for each Medicaid
14 obstetrical day of care provided in State fiscal year 2005
15 by each Illinois general acute care hospital that was
16 designated a level II or II+ perinatal center as of
17 December 31, 2006, and that had a case mix index equal to
18 or greater than the 35th percentile of the case mix indices
19 for all level II and II+ perinatal centers.

20 (g) Trauma adjustment.

21 (1) In addition to rates paid for inpatient hospital
22 services, the Department shall pay each Illinois general
23 acute care hospital designated as a trauma center as of
24 July 1, 2007, a payment equal to 3.75 multiplied by the
25 hospital's State fiscal year 2005 Medicaid capital
26 payments.

1 (2) In addition to rates paid for inpatient hospital
2 services, the Department shall pay \$400 for each Medicaid
3 acute inpatient day of care provided in State fiscal year
4 2005 by each Illinois general acute care hospital that was
5 designated a level II trauma center, as defined in 89 Ill.
6 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,
7 2007.

8 (3) In addition to rates paid for inpatient hospital
9 services, the Department shall pay \$235 for each Illinois
10 Medicaid acute inpatient day of care provided in State
11 fiscal year 2005 by each level I pediatric trauma center
12 located outside of Illinois that had more than 8,000
13 Illinois Medicaid inpatient days in State fiscal year 2005.

14 (h) Supplemental tertiary care adjustment. In addition to
15 rates paid for inpatient services, the Department shall pay to
16 each Illinois hospital eligible for tertiary care adjustment
17 payments under 89 Ill. Adm. Code 148.296, as in effect for
18 State fiscal year 2007, a supplemental tertiary care adjustment
19 payment equal to the tertiary care adjustment payment required
20 under 89 Ill. Adm. Code 148.296, as in effect for State fiscal
21 year 2007.

22 (i) Crossover adjustment. In addition to rates paid for
23 inpatient services, the Department shall pay each Illinois
24 general acute care hospital that had a ratio of crossover days
25 to total inpatient days for medical assistance programs
26 administered by the Department (utilizing information from

1 2005 paid claims) greater than 50%, and a case mix index
2 greater than the 65th percentile of case mix indices for all
3 Illinois hospitals, a rate of \$1,125 for each Medicaid
4 inpatient day including crossover days.

5 (j) Magnet hospital adjustment. In addition to rates paid
6 for inpatient hospital services, the Department shall pay to
7 each Illinois general acute care hospital and each Illinois
8 freestanding children's hospital that, as of February 1, 2008,
9 was recognized as a Magnet hospital by the American Nurses
10 Credentialing Center and that had a case mix index greater than
11 the 75th percentile of case mix indices for all Illinois
12 hospitals amounts as follows:

13 (1) For hospitals located in a county whose eligibility
14 growth factor is greater than the mean, \$450 multiplied by
15 the eligibility growth factor for the county in which the
16 hospital is located for each Medicaid inpatient day of care
17 provided by the hospital during State fiscal year 2005.

18 (2) For hospitals located in a county whose eligibility
19 growth factor is less than or equal to the mean, \$225
20 multiplied by the eligibility growth factor for the county
21 in which the hospital is located for each Medicaid
22 inpatient day of care provided by the hospital during State
23 fiscal year 2005.

24 For purposes of this subsection, "eligibility growth
25 factor" means the percentage by which the number of Medicaid
26 recipients in the county increased from State fiscal year 1998

1 to State fiscal year 2005.

2 (k) For purposes of this Section, a hospital that is
3 enrolled to provide Medicaid services during State fiscal year
4 2005 shall have its utilization and associated reimbursements
5 annualized prior to the payment calculations being performed
6 under this Section.

7 (l) 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 (m) For purposes of this Section, in determining the
15 percentile ranking of an Illinois hospital's case mix index or
16 capital costs, hospitals described in subsection (b) of Section
17 5A-3 shall be excluded from the ranking.

18 (n) Definitions. Unless the context requires otherwise or
19 unless provided otherwise in this Section, the terms used in
20 this Section for qualifying criteria and payment calculations
21 shall have the same meanings as those terms have been given in
22 the Illinois Department's administrative rules as in effect on
23 March 1, 2008. Other terms shall be defined by the Illinois
24 Department by rule.

25 As used in this Section, unless the context requires
26 otherwise:

1 "Base inpatient payments" means, for a given hospital, the
2 sum of base payments for inpatient services made on a per diem
3 or per admission (DRG) basis, excluding those portions of per
4 admission payments that are classified as capital payments.
5 Disproportionate share hospital adjustment payments, Medicaid
6 Percentage Adjustments, Medicaid High Volume Adjustments, and
7 outlier payments, as defined by rule by the Department as of
8 January 1, 2008, are not base payments.

9 "Capital costs" means, for a given hospital, the total
10 capital costs determined using the most recent 2005 Medicare
11 cost report as contained in the Healthcare Cost Report
12 Information System file, for the quarter ending on December 31,
13 2006, divided by the total inpatient days from the same cost
14 report to calculate a capital cost per day. The resulting
15 capital cost per day is inflated to the midpoint of State
16 fiscal year 2009 utilizing the national hospital market price
17 proxies (DRI) hospital cost index. If a hospital's 2005
18 Medicare cost report is not contained in the Healthcare Cost
19 Report Information System, the Department may obtain the data
20 necessary to compute the hospital's capital costs from any
21 source available, including, but not limited to, records
22 maintained by the hospital provider, which may be inspected at
23 all times during business hours of the day by the Illinois
24 Department or its duly authorized agents and employees.

25 "Case mix index" means, for a given hospital, the sum of
26 the DRG relative weighting factors in effect on January 1,

1 2005, for all general acute care admissions for State fiscal
2 year 2005, excluding Medicare crossover admissions and
3 transplant admissions reimbursed under 89 Ill. Adm. Code
4 148.82, divided by the total number of general acute care
5 admissions for State fiscal year 2005, excluding Medicare
6 crossover admissions and transplant admissions reimbursed
7 under 89 Ill. Adm. Code 148.82.

8 "Medicaid inpatient day" means, for a given hospital, the
9 sum of days of inpatient hospital days provided to recipients
10 of medical assistance under Title XIX of the federal Social
11 Security Act, excluding days for individuals eligible for
12 Medicare under Title XVIII of that Act (Medicaid/Medicare
13 crossover days), as tabulated from the Department's paid claims
14 data for admissions occurring during State fiscal year 2005
15 that was adjudicated by the Department through March 23, 2007.

16 "Medicaid obstetrical day" means, for a given hospital, the
17 sum of days of inpatient hospital days grouped by the
18 Department to DRGs of 370 through 375 provided to recipients of
19 medical assistance under Title XIX of the federal Social
20 Security Act, excluding days for individuals eligible for
21 Medicare under Title XVIII of that Act (Medicaid/Medicare
22 crossover days), as tabulated from the Department's paid claims
23 data for admissions occurring during State fiscal year 2005
24 that was adjudicated by the Department through March 23, 2007.

25 "Outpatient ambulatory procedure listing payments" means,
26 for a given hospital, the sum of payments for ambulatory

1 procedure listing services, as described in 89 Ill. Adm. Code
2 148.140(b), provided to recipients of medical assistance under
3 Title XIX of the federal Social Security Act, excluding
4 payments for individuals eligible for Medicare under Title
5 XVIII of the Act (Medicaid/Medicare crossover days), as
6 tabulated from the Department's paid claims data for services
7 occurring in State fiscal year 2005 that were adjudicated by
8 the Department through March 23, 2007.

9 (o) The Department may adjust payments made under this
10 Section 12.2 to comply with federal law or regulations
11 regarding hospital-specific payment limitations on
12 government-owned or government-operated hospitals.

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

24 (q) For State fiscal years 2012 and 2013, the Department
25 may make recommendations to the General Assembly regarding the
26 use of more recent data for purposes of calculating the

1 assessment authorized under Section 5A-2 and the payments
2 authorized under this Section 5A-12.2.

3 (305 ILCS 5/5A-14)

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

5 (a) Section 5A-2 is repealed on July 1, 2013 ~~2008~~.

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

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

8 (d) Section 5A-12.2 is repealed on July 1, 2013.

9 (Source: P.A. 93-659, eff. 2-3-04; 94-242, eff. 7-18-05.)

10 (305 ILCS 5/15-2) (from Ch. 23, par. 15-2)

11 Sec. 15-2. County Provider Trust Fund.

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

17 (b) The Fund is created solely for the purposes of
18 receiving, investing, and distributing monies in accordance
19 with this Article XV. The Fund shall consist of:

20 (1) All monies collected or received by the Illinois
21 Department under Section 15-3 of this Code;

22 (2) All federal financial participation monies
23 received by the Illinois Department pursuant to Title XIX
24 of the Social Security Act, 42 U.S.C. 1396b ~~1396(b)~~,

1 attributable to eligible expenditures made by the Illinois
2 Department pursuant to Section 15-5 of this Code;

3 (3) All federal moneys received by the Illinois
4 Department pursuant to Title XXI of the Social Security Act
5 attributable to eligible expenditures made by the Illinois
6 Department pursuant to Section 15-5 of this Code; and

7 (4) All other monies received by the Fund from any
8 source, including interest thereon.

9 (c) Disbursements from the Fund shall be by warrants drawn
10 by the State Comptroller upon receipt of vouchers duly executed
11 and certified by the Illinois Department and shall be made
12 only:

13 (1) For hospital inpatient care, hospital outpatient
14 care, care provided by other outpatient facilities
15 operated by a county, and disproportionate share hospital
16 adjustment payments made under Title XIX of the Social
17 Security Act and Article V of this Code as required by
18 Section 15-5 of this Code;

19 (1.5) For services provided by county providers
20 pursuant to Section 5-11 of this Code;

21 (2) For the reimbursement of administrative expenses
22 incurred by county providers on behalf of the Illinois
23 Department as permitted by Section 15-4 of this Code;

24 (3) For the reimbursement of monies received by the
25 Fund through error or mistake;

26 (4) For the payment of administrative expenses

1 necessarily incurred by the Illinois Department or its
2 agent in performing the activities required by this Article
3 XV;

4 (5) For the payment of any amounts that are
5 reimbursable to the federal government, attributable
6 solely to the Fund, and required to be paid by State
7 warrant; and

8 (6) For hospital inpatient care, hospital outpatient
9 care, care provided by other outpatient facilities
10 operated by a county, and disproportionate share hospital
11 adjustment payments made under Title XXI of the Social
12 Security Act, pursuant to Section 15-5 of this Code.

13 (Source: P.A. 91-24, eff. 7-1-99; 92-370, eff. 8-15-01.)

14 (305 ILCS 5/15-3) (from Ch. 23, par. 15-3)

15 Sec. 15-3. Intergovernmental Transfers.

16 (a) Each qualifying county shall make an annual
17 intergovernmental transfer to the Illinois Department in an
18 amount equal to ~~71.7%~~ of the difference between the total
19 payments made by the Illinois Department ~~to such county~~
20 ~~provider for hospital services under Titles XIX and XXI of the~~
21 ~~Social Security Act or pursuant to subsection (a) of Section~~
22 15-5 ~~5-11~~ of this Code and the total federal financial
23 participation monies received by the fund in each fiscal year
24 ending June 30 ~~(or fraction thereof during the fiscal year~~
25 ~~ending June 30, 1993) and \$108,800,000 (or fraction thereof),~~

1 ~~except that the annual intergovernmental transfer shall not~~
2 ~~exceed the total payments made by the Illinois Department to~~
3 ~~such county provider for hospital services under this Code,~~
4 ~~less the sum of (i) 50% of payments reimbursable under the~~
5 ~~Social Security Act at a rate of 50% and (ii) 65% of payments~~
6 ~~reimbursable under the Social Security Act at a rate of 65%, in~~
7 ~~each fiscal year ending June 30 (or fraction thereof).~~

8 (b) The payment schedule for the intergovernmental
9 transfer made hereunder shall be established by
10 intergovernmental agreement between the Illinois Department
11 and the applicable county, which agreement shall at a minimum
12 provide:

13 (1) For periodic payments no less frequently than
14 monthly to the county provider for inpatient and outpatient
15 approved or adjudicated claims and for disproportionate
16 share adjustment payments as may be specified in the
17 Illinois Title XIX State plan. ~~under Section 5 5.02 of this~~
18 ~~Code (in the initial year, for services after July 1, 1991,~~
19 ~~or such other date as an approved State Medical Assistance~~
20 ~~Plan shall provide).~~

21 (2) (Blank.) ~~For periodic payments no less frequently~~
22 ~~than monthly to the county provider for supplemental~~
23 ~~disproportionate share payments hereunder based on a~~
24 ~~federally approved State Medical Assistance Plan.~~

25 (3) For calculation of the intergovernmental transfer
26 payment to be made by the county equal to ~~71.7%~~ of the

1 difference between the amount of the periodic payments to
2 county providers ~~payment~~ and any amount of federal
3 financial participation due the Illinois Department under
4 Titles XIX and XXI of the Social Security Act as a result
5 of such payments to county providers. ~~the base amount,~~
6 ~~provided, however, that if the periodic payment for any~~
7 ~~period is less than the base amount for such period, the~~
8 ~~base amount for the succeeding period (and any successive~~
9 ~~period if necessary) shall be increased by the amount of~~
10 ~~such shortfall.~~

11 (4) For an intergovernmental transfer methodology
12 which obligates the Illinois Department to notify the
13 county ~~and county provider~~ in writing of each impending
14 periodic payment and the intergovernmental transfer
15 payment attributable thereto and which obligates the
16 Comptroller to release the periodic payment to the county
17 provider within one working day of receipt of the
18 intergovernmental transfer payment from the county.

19 (Source: P.A. 91-24, eff. 7-1-99; 92-370, eff. 8-15-01.)

20 (305 ILCS 5/15-5) (from Ch. 23, par. 15-5)

21 Sec. 15-5. Disbursements from the Fund.

22 (a) The monies in the Fund shall be disbursed only as
23 provided in Section 15-2 of this Code and as follows:

24 (1) To the extent that such costs are reimbursable
25 under federal law, to pay the county hospitals' inpatient

1 reimbursement rates ~~rate~~ based on actual costs incurred,
2 trended forward annually by an inflation index. ~~and~~
3 ~~supplemented by teaching, capital, and other direct and~~
4 ~~indirect costs, according to a State plan approved by the~~
5 ~~federal government. Effective October 1, 1992, the~~
6 ~~inpatient reimbursement rate (including any~~
7 ~~disproportionate or supplemental disproportionate share~~
8 ~~payments) for hospital services provided by county~~
9 ~~operated facilities within the County shall be no less than~~
10 ~~the reimbursement rates in effect on June 1, 1992, except~~
11 ~~that this minimum shall be adjusted as of July 1, 1992 and~~
12 ~~each July 1 thereafter through July 1, 2002 by the annual~~
13 ~~percentage change in the per diem cost of inpatient~~
14 ~~hospital services as reported in the most recent annual~~
15 ~~Medicaid cost report. Effective July 1, 2003, the rate for~~
16 ~~hospital inpatient services provided by county hospitals~~
17 ~~shall be the rate in effect on January 1, 2003, except that~~
18 ~~this minimum may be adjusted by the Illinois Department to~~
19 ~~ensure compliance with aggregate and hospital specific~~
20 ~~federal payment limitations.~~

21 (2) To the extent that such costs are reimbursable
22 under federal law, to pay county hospitals and county
23 operated outpatient facilities for outpatient services
24 based on a federally approved methodology to cover the
25 maximum allowable costs. ~~per patient visit. Effective~~
26 ~~October 1, 1992, the outpatient reimbursement rate for~~

1 ~~outpatient services provided by county hospitals and~~
2 ~~county operated outpatient facilities shall be no less than~~
3 ~~the reimbursement rates in effect on June 1, 1992, except~~
4 ~~that this minimum shall be adjusted as of July 1, 1992 and~~
5 ~~each July 1 thereafter through July 1, 2002 by the annual~~
6 ~~percentage change in the per diem cost of inpatient~~
7 ~~hospital services as reported in the most recent annual~~
8 ~~Medicaid cost report. Effective July 1, 2003, the Illinois~~
9 ~~Department shall by rule establish rates for outpatient~~
10 ~~services provided by county hospitals and other~~
11 ~~county operated facilities within the County that are in~~
12 ~~compliance with aggregate and hospital specific federal~~
13 ~~payment limitations.~~

14 (3) To pay the county hospitals ~~hospitals'~~
15 disproportionate share hospital adjustment payments as may
16 be specified in the Illinois Title XIX State plan. ~~as~~
17 ~~established by the Illinois Department under Section~~
18 ~~5 5.02 of this Code. Effective October 1, 1992, the~~
19 ~~disproportionate share payments for hospital services~~
20 ~~provided by county operated facilities within the County~~
21 ~~shall be no less than the reimbursement rates in effect on~~
22 ~~June 1, 1992, except that this minimum shall be adjusted as~~
23 ~~of July 1, 1992 and each July 1 thereafter through July 1,~~
24 ~~2002 by the annual percentage change in the per diem cost~~
25 ~~of inpatient hospital services as reported in the most~~
26 ~~recent annual Medicaid cost report. Effective July 1, 2003,~~

1 ~~the Illinois Department may by rule establish rates for~~
2 ~~disproportionate share payments to county hospitals that~~
3 ~~are in compliance with aggregate and hospital-specific~~
4 ~~federal payment limitations.~~

5 (3.5) To pay county providers for services provided
6 pursuant to Section 5-11 of this Code.

7 (4) To reimburse the county providers for expenses
8 contractually assumed pursuant to Section 15-4 of this
9 Code.

10 (5) To pay the Illinois Department its necessary
11 administrative expenses relative to the Fund and other
12 amounts agreed to, if any, by the county providers in the
13 agreement provided for in subsection (c).

14 (6) To pay the county providers any other amount due
15 according to a federally approved State plan, including but
16 not limited to payments made under the provisions of
17 Section 701(d)(3)(B) of the federal Medicare, Medicaid,
18 and SCHIP Benefits Improvement and Protection Act of 2000.
19 Intergovernmental transfers supporting payments under this
20 paragraph (6) shall not be subject to the computation
21 described in subsection (a) of Section 15-3 of this Code,
22 but shall be computed as the difference between the total
23 of such payments made by the Illinois Department to county
24 providers less any amount of federal financial
25 participation due the Illinois Department under Titles XIX
26 and XXI of the Social Security Act as a result of such

1 payments to county providers.

2 (b) The Illinois Department shall promptly seek all
3 appropriate amendments to the Illinois Title XIX State Plan to
4 maximize reimbursement, including disproportionate share
5 hospital adjustment payments, to the county providers ~~effect~~
6 ~~the foregoing payment methodology.~~

7 (c) (Blank). ~~The Illinois Department shall implement the~~
8 ~~changes made by Article 3 of this amendatory Act of 1992~~
9 ~~beginning October 1, 1992. All terms and conditions of the~~
10 ~~disbursement of monies from the Fund not set forth expressly in~~
11 ~~this Article shall be set forth in the agreement executed under~~
12 ~~the Intergovernmental Cooperation Act so long as those terms~~
13 ~~and conditions are not inconsistent with this Article or~~
14 ~~applicable federal law. The Illinois Department shall report in~~
15 ~~writing to the Hospital Service Procurement Advisory Board and~~
16 ~~the Health Care Cost Containment Council by October 15, 1992,~~
17 ~~the terms and conditions of all such initial agreements and,~~
18 ~~where no such initial agreement has yet been executed with a~~
19 ~~qualifying county, the Illinois Department's reasons that each~~
20 ~~such initial agreement has not been executed. Copies and~~
21 ~~reports of amended agreements following the initial agreements~~
22 ~~shall likewise be filed by the Illinois Department with the~~
23 ~~Hospital Service Procurement Advisory Board and the Health Care~~
24 ~~Cost Containment Council within 30 days following their~~
25 ~~execution. The foregoing filing obligations of the Illinois~~
26 ~~Department are informational only, to allow the Board and~~

1 ~~Council, respectively, to better perform their public roles,~~
2 ~~except that the Board or Council may, at its discretion, advise~~
3 ~~the Illinois Department in the case of the failure of the~~
4 ~~Illinois Department to reach agreement with any qualifying~~
5 ~~county by the required date.~~

6 (d) The payments provided for herein are intended to cover
7 services rendered on and after July 1, 1991, and any agreement
8 executed between a qualifying county and the Illinois
9 Department pursuant to this Section may relate back to that
10 date, provided the Illinois Department obtains federal
11 approval. Any changes in payment rates resulting from the
12 provisions of Article 3 of this amendatory Act of 1992 are
13 intended to apply to services rendered on or after October 1,
14 1992, and any agreement executed between a qualifying county
15 and the Illinois Department pursuant to this Section may be
16 effective as of that date.

17 (e) If one or more hospitals file suit in any court
18 challenging any part of this Article XV, payments to hospitals
19 from the Fund under this Article XV shall be made only to the
20 extent that sufficient monies are available in the Fund and
21 only to the extent that any monies in the Fund are not
22 prohibited from disbursement and may be disbursed under any
23 order of the court.

24 (f) All payments under this Section are contingent upon
25 federal approval of changes to the Title XIX State plan, if
26 that approval is required.

1 (Source: P.A. 92-370, eff. 8-15-01; 93-20, eff. 6-20-03.)

2 (305 ILCS 5/15-8) (from Ch. 23, par. 15-8)

3 Sec. 15-8. Federal disallowances. In the event of any
4 federal deferral or disallowance of any federal matching funds
5 obtained through this Article which have been disbursed by the
6 Illinois Department under this Article based upon challenges to
7 reimbursement methodologies, ~~methodology or disproportionate~~
8 ~~share methodology~~, the full faith and credit of the county is
9 pledged for repayment by the county of those amounts deferred
10 or disallowed to the Illinois Department.

11 (Source: P.A. 87-13.)

12 (305 ILCS 5/15-10 new)

13 Sec. 15-10. Disproportionate share hospital adjustment
14 payments.

15 (a) The provisions of this Section become operative if:

16 (1) The federal government approves State Plan
17 Amendment transmittal number 08-06 or a State Plan
18 Amendment that permits disproportionate share hospital
19 adjustment payments to be made to county hospitals.

20 (2) Proposed federal regulations, or other regulations
21 or limitations driven by the federal government,
22 negatively impact the net revenues realized by county
23 providers from the Fund during a State fiscal year by more
24 than 15%, as measured by the aggregate average net monthly

1 payment received by the county providers from the Fund from
2 July 2007 through May 2008.

3 (3) The county providers have in good faith submitted
4 timely, complete, and accurate cost reports and
5 supplemental documents as required by the Illinois
6 Department.

7 (4) the county providers maintain and bill for service
8 volumes to individuals eligible for medical assistance
9 under this Code that are no lower than 85% of the volumes
10 provided by and billed to the Illinois Department by the
11 county providers associated with payments received by the
12 county providers from July 2007 through May 2008. Given the
13 substantial financial burdens of the county associated
14 with uncompensated care, the Illinois Department shall
15 make good faith efforts to work with the county to maintain
16 Medicaid volumes to the extent that the county has the
17 adequate capacity to meet the obligations of patient
18 volumes.

19 The Illinois Department and the county shall include in an
20 intergovernmental agreement the process by which these
21 conditions are assessed. The parties may, if necessary,
22 contract with a large, nationally recognized public accounting
23 firm to carry out this function.

24 (b) If the conditions of subsection (a) are met, and
25 subject to appropriation or other available funding for such
26 purpose, the Illinois Department shall make a payment or

1 otherwise make funds available to the county hospitals, during
2 the lapse period, that provides for total payments to be at
3 least at a level that is equivalent to the total
4 fee-for-service payments received by the county providers that
5 are enrolled with the Illinois Department to provide services
6 during the fiscal year of the payment from the Fund from July
7 2007 through May 2008 multiplied by twelve-elevenths.

8 (c) In addition, notwithstanding any provision in
9 subsection (a), the Illinois Department shall maximize
10 disproportionate share hospital adjustment payments to the
11 county hospitals that, at a minimum, are 42% of the State's
12 federal fiscal year 2007 disproportionate share allocation.

13 (d) For the purposes of this Section, "net revenues" means
14 the difference between the total fee-for-service payments made
15 by the Illinois Department to county providers less the
16 intergovernmental transfer made by the county in support of
17 those payments.

18 (e) If (i) the disproportionate share hospital adjustment
19 State Plan Amendment referenced in subdivision (a)(1) is not
20 approved, or (ii) any reconciliation of payments to costs
21 incurred would require repayment to the federal government of
22 at least \$2,500,000, or (iii) there is no funding available for
23 the Illinois Department's obligations under subsection (b),
24 the Illinois Department, the county, and the leadership of the
25 General Assembly shall designate individuals to convene,
26 within 30 days, to discuss how mutual funding goals for the

1 county providers are to be achieved.

2 (305 ILCS 5/15-11 new)

3 Sec. 15-11. Uses of State funds.

4 (a) At any point, if State revenues referenced in
5 subsection (b) or (c) of Section 15-10 or additional State
6 grants are disbursed to the Cook County Health and Hospitals
7 System, all funds may be used only for the following:

8 (1) medical services provided at hospitals or clinics
9 owned and operated by the Cook County Bureau of Health
10 Services; or

11 (2) information technology to enhance billing
12 capabilities for medical claiming and reimbursement.

13 (b) State funds may not be used for the following:

14 (1) non-clinical services, except services that may be
15 required by accreditation bodies or State or federal
16 regulatory or licensing authorities;

17 (2) non-clinical support staff, except as pursuant to
18 paragraph (1) of this subsection; or

19 (3) capital improvements, other than investments in
20 medical technology, except for capital improvements that
21 may be required by accreditation bodies or State or federal
22 regulatory or licensing authorities.

23 Section 99. Effective date. This Act takes effect upon
24 becoming law.