AN ACT concerning public aid.

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

Section 5. The Excellence in Academic Medicine Act is amended by changing Sections 25, 30, and 35 as follows:

(30 ILCS 775/25)

Sec. 25. Medical research and development challenge program.

(a) The State shall provide the following financial incentives to draw private and federal funding for biomedical research, technology and programmatic development:

(1) Each qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital shall receive a percentage of the amount available for distribution from the National Institutes of Health Account, equal to that hospital's percentage of the total contracts and grants from the National Institutes of Health awarded to qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospitals and their affiliated medical schools during the preceding calendar year. These amounts shall be paid from the National Institutes of Health Account.

(2) Each qualified Chicago Medicare Metropolitan

Statistical Area academic medical center hospital shall receive a payment from the State equal to 25% of all funded grants (other than grants funded by the State of Illinois or the National Institutes of Health) for biomedical research, technology, or programmatic development received by that qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital during the preceding calendar year. These amounts shall be paid from the Philanthropic Medical Research Account.

(3) Each qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital that (i) contributes 40% of the funding for a biomedical research or technology project or a programmatic development project and (ii) obtains contributions from the private sector equal to 40% of the funding for the project shall receive from the State an amount equal to 20% of the funding for the project upon submission of documentation demonstrating those facts to the Comptroller; however, the State shall not be required to make the payment unless the contribution of the qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital exceeds $100,000. The documentation must be submitted within 180 days of the beginning of the fiscal year. These amounts shall be paid from the Market Medical Research Account.

(b) No hospital under the Medical Research and Development Challenge Program shall receive more than 20% of the total

amount appropriated to the Medical Research and Development Fund.

The amounts received under the Medical Research and Development Challenge Program by the Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals, considered as a single entity, shall not exceed an amount equal to one-sixth of the total amount available for distribution from the Medical Research and Development Fund, multiplied by a fraction, the numerator of which is the amount awarded the Southern Illinois University School of Medicine and its affiliated teaching hospitals in grants or contracts by the National Institutes of Health and the denominator of which is $8,000,000.

(c) On or after the 180th day of the fiscal year the Comptroller may transfer unexpended funds in any account of the Medical Research and Development Fund to pay appropriate claims against another account.

(d) The amounts due each qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital under the Medical Research and Development Fund from the National Institutes of Health Account, the Philanthropic Medical Research Account, and the Market Medical Research Account shall be combined and one quarter of the amount payable to each qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital shall be paid on the fifteenth working day after July 1, October 1, January 1, and

March 1 or on a schedule determined by the Department of Healthcare and Family Services by rule that results in a more expeditious payment of the amounts due.

(e) The Southern Illinois University School of Medicine in Springfield and its affiliated primary teaching hospitals, considered as a single entity, shall be deemed to be a qualified Chicago Medicare Metropolitan Statistical Area academic medical center hospital for the purposes of this Section.

(f) In each State fiscal year, beginning in fiscal year 2008, the full amount appropriated for the Medical research and development challenge program for that fiscal year shall be distributed as described in this Section.

(Source: P.A. 95-744, eff. 7-18-08.)

(30 ILCS 775/30)

Sec. 30. Post-Tertiary Clinical Services Program. The State shall provide incentives to develop and enhance post-tertiary clinical services. Qualified academic medical center hospitals as defined in Section 15 may receive funding under the Post-Tertiary Clinical Services Program for up to 3 qualified programs as defined in Section 15 in any given year; however, qualified academic medical center hospitals may receive continued funding for previously funded qualified programs rather than receive funding for a new program so long as the number of qualified programs receiving funding does not

exceed 3. Each qualified academic medical center hospital as defined in Section 15 shall receive an equal percentage of the Post-Tertiary Clinical Services Fund to be used in the funding of qualified programs. In each State fiscal year, beginning in fiscal year 2008, the full amount appropriated for the Post-Tertiary Clinical Services Program for that fiscal year shall be distributed as described in this Section. One quarter of the amount payable to each qualified academic medical center hospital shall be paid on the fifteenth working day after July 1, October 1, January 1, and March 1 or on a schedule determined by the Department of Healthcare and Family Services by rule that results in a more expeditious payment of the amounts due.

(Source: P.A. 95-744, eff. 7-18-08.)

(30 ILCS 775/35)

Sec. 35. Independent Academic Medical Center Program. There is created an Independent Academic Medical Center Program to provide incentives to develop and enhance the independent academic medical center hospital. In each State fiscal year, beginning in fiscal year 2002, the independent academic medical center hospital shall receive funding under the Program, equal to the full amount appropriated for that purpose for that fiscal year. In each fiscal year, one quarter of the amount payable to the independent academic medical center hospital shall be paid on the fifteenth working day after July 1,

October 1, January 1, and March 1 or on a schedule determined by the Department of Healthcare and Family Services by rule that results in a more expeditious payment of the amounts due.

(Source: P.A. 92-10, eff. 6-11-01.)

Section 10. The Illinois Public Aid Code is amended by changing Sections 5A-4, 5A-8, 5A-12.2, and 5A-14 and by adding Section 5A-12.3 as follows:

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

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

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

the fourteenth State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after: (i) the Department notifies the hospital provider, in writing, that the payment methodologies to hospitals required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waiver under 42 CFR 433.68 for the assessment imposed by 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, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, and the waiver granted under 42 CFR 433.68, all installments otherwise due under 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-12.1 or Section 5A-12.2, whichever is applicable for that fiscal year.

(a-5) The Illinois Department may, for the purpose of maximizing federal revenue, 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 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, by the total assessment for the State fiscal year imposed under 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. 94-242, eff. 7-18-05; 95-331, eff. 8-21-07; 95-859, eff. 8-19-08.)

(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 Articles V, V-A, VI, and XIV of this Code, under the Children's Health Insurance Program Act, ~~and~~ under the Covering ALL KIDS Health Insurance Act, and under the

Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act.

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

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

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

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

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

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

(7) For State fiscal years 2004 and 2005 for making transfers to the Health and Human Services Medicaid Trust Fund, including 20% of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. For State fiscal year 2006 for making transfers to the Health and Human Services Medicaid Trust Fund of up to $130,000,000 per year of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. 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) For State fiscal year 2007 for making transfers of the moneys 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 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.

(7.8) For State fiscal year 2008, for making transfers of the moneys 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 and Human Services

Medicaid Trust Fund $40,000,000

Long-Term Care Provider Fund $60,000,000

General Revenue Fund ..... $160,000,000.

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.

(7.9) For State fiscal years 2009 through 2013, for making transfers of the moneys 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 and Human Services

Medicaid Trust Fund $20,000,000

Long Term Care Provider Fund $30,000,000

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

Except as provided under this paragraph, transfers under this paragraph shall be made within 7 business days after the payments have been received pursuant to the

schedule of payments provided in subsection (a) of Section 5A-4. For State fiscal year 2009, transfers to the General Revenue Fund under this paragraph shall be made on or before June 30, 2009, as sufficient funds become available in the Hospital Provider Fund to both make the transfers and continue hospital payments.

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

(305 ILCS 5/5A-12.2)

(Section scheduled to be repealed on July 1, 2013)

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2008, 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 seventh 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 this Article is determined to be a permissible tax under Title XIX of the Social Security

Act.

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

(b) Across-the-board inpatient adjustment.

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

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

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

(4) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois children's hospital an amount equal to 20% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005 and an additional amount equal to 20% of the base inpatient payments paid to the hospital for psychiatric services provided in State fiscal year 2005.

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

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

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

(c) Outpatient adjustment.

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

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

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

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

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

(e) Capital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay an

additional payment to each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% (as calculated by the Department for the rate year 2007 disproportionate share determination) amounts as follows:

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

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

(f) Obstetrical care adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay $1,500 for each Medicaid obstetrical day of care provided in State fiscal year 2005

by each Illinois rural hospital that had a Medicaid obstetrical percentage (Medicaid obstetrical days divided by Medicaid inpatient days) greater than 15% for State fiscal year 2005.

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

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

(g) Trauma adjustment.

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

payments.

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

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

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

(i) Crossover adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois general acute care hospital that had a ratio of crossover days to total inpatient days for medical assistance programs

administered by the Department (utilizing information from 2005 paid claims) greater than 50%, and a case mix index greater than the 65th percentile of case mix indices for all Illinois hospitals, a rate of $1,125 for each Medicaid inpatient day including crossover days.

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

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

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

For purposes of this subsection, "eligibility growth factor" means the percentage by which the number of Medicaid

recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

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

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

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

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

As used in this Section, unless the context requires

otherwise:

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

"Capital costs" means, for a given hospital, the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies (DRI) hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department may obtain the data necessary to compute the hospital's capital costs 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.

"Case mix index" means, for a given hospital, the sum of

the DRG relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, divided by the total number of general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

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

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

"Outpatient ambulatory procedure listing payments" means,

for a given hospital, the sum of payments for ambulatory procedure listing services, as described in 89 Ill. Adm. Code 148.140(b), 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 2005 that were adjudicated by the Department through March 23, 2007.

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

(p) 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 (p) shall be given retroactive effect so that they shall be deemed to have taken effect as of the effective date of this Section.

(q) For State fiscal years 2012 and 2013, the Department may make recommendations to the General Assembly regarding the

use of more recent data for purposes of calculating the assessment authorized under Section 5A-2 and the payments authorized under this Section 5A-12.2.

(Source: P.A. 95-859, eff. 8-19-08.)

(305 ILCS 5/5A-12.3 new)

Sec. 5A-12.3. Hospital Medicaid Stimulus Payments.

(a) Supplemental payments. Subject to federal approval and as soon as practicable after the effective date of this amendatory Act of the 96th General Assembly, the Department shall make a one-time Medicaid supplemental payment to hospitals for inpatient and outpatient Medicaid services. This payment shall be the sum of the following payment methodologies:

(1) In addition to the rates paid for outpatient hospital services, the Department shall pay all rural hospitals a supplemental outpatient payment in an amount equal to the hospital's outpatient ambulatory procedure listing payments for Group 3 as defined in 89 Ill. Adm. Code 148.140(b)(1)(C), for State fiscal year 2005. For a hospital qualified as a critical access hospital, as designated by the Illinois Department of Public Health in accordance with 42 CFR 485, Subpart F (2001), the payment amount under this paragraph (1) shall be multiplied by 3.5. In order to qualify for payments under this Section a hospital must:

(A) Be a hospital that is licensed by the Department of Public Health under the Hospital Licensing Act, certified by that Department to participate in the Illinois Medicaid Program, and enrolled with the Department of Healthcare and Family Services to participate in the Illinois Medicaid Program;

(B) Provide services as required under 77 Ill. Adm. Code 250.710 in an emergency room subject to the requirements under either 77 Ill. Adm. Code 250.2440(k) or 77 Ill. Adm. Code 250.2630(k); and

(C) Be a rural Illinois hospital, as defined at 89 Ill. Adm. Code 148.25(g)(3).

(2) In addition to the rates paid for inpatient hospital services, the Department shall pay $175 for each Medicaid obstetrical day of care by each Illinois general acute care hospital that was designated a level III perinatal center as of July 1, 2009 and provided more than 2,000 Medicaid obstetrical days of service.

(3) In addition to the rates paid for inpatient hospital services, the Department shall pay $22 for each Medicaid inpatient day to each hospital designated as a Level I Trauma Center. For the purpose of this Section, a Level I Trauma Center is a hospital designated by the Department of Public Health using the criteria under 77 Ill. Adm. Code 515.2030 or 77 Ill. Adm. Code 515.2035 as of

July 1, 2009. For the purposes of this payment, hospitals located in the same city that alternate their Level I Trauma Center designation as defined in 89 Ill. Adm. Code 148.295(a)(2) shall both be eligible to receive this payment.

(4) In addition to the rates paid for inpatient hospital services, the Department shall pay $37 for each Medicaid inpatient day.

(5) In addition to the rates paid for inpatient hospital services, the Department shall pay an additional $35 for each Medicaid inpatient day to each hospital qualifying for a payment in paragraph (4) of this subsection (a) that also qualifies for payments under 89 Ill. Adm. Code 148.120 or 89 Ill. Adm. Code 148.122 for the rate period beginning October 1, 2009.

(b) Exclusions from payments under this Section.

(1) A hospital that is operated by a State agency, a State university, or a county with a population of 3,000,000 or more is not eligible for any payment under this Section.

(2) A hospital as defined in 89 Ill. Adm. Code 149.50(c)(4) is not eligible for any payment under paragraph (4) or (5) of subsection (a) of this Section.

(3) A hospital as defined in 89 Ill. Adm. Code 149.50(c)(1) or 89 Ill. Adm. Code 149.50(c)(2) is not eligible for any payment under paragraph (5) of subsection

(a) of this Section.

(4) A hospital that ceases operations prior to federal approval of, and adoption of administrative rules necessary to effect, payments under this Section is not eligible for any payment under this Section.

(5) A hospital that has filed for bankruptcy or is operating under bankruptcy protection under any Chapter of Title 11 of the United States Code (Bankruptcy) is not eligible for any payment under this Section.

(c) Definitions. Unless the context requires otherwise or unless provided otherwise in this Section, the terms used in this Section for qualifying criteria and payment calculations shall have the same meanings as those terms have been given in the Department's administrative rules as in effect on March 1, 2008. As used in this Section, unless the context requires otherwise:

(1) "Medicaid inpatient day" has the same meaning as defined in subsection (n) of Section 5A-12.2.

(2) "Hospital" means any facility located in Illinois that is required to submit cost reports as mandated under 89 Ill. Adm. Code 148.210.

(3) "Medicaid obstetrical day" has the same meaning ascribed to it in subsection (n) of Section 5A-12.2.

(4) "Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services, as described in 89

Ill. Adm. Code 148.140(b)(1)(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 2005 that were adjudicated by the Department through March 23, 2007.

(d) Funding sources. Payments under this Section shall be made from the Healthcare Provider Relief Fund.

(e) Adjustments. The Department may pay a portion of payments made under this Section in a subsequent State fiscal year to comply with federal law or regulations regarding hospital-specific payment limitations.

(305 ILCS 5/5A-14)

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

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

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

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

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

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

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

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