Sen. Jeffrey M. Schoenberg

Filed: 10/29/2009

1 AMENDMENT TO HOUSE BILL 542

2 AMENDMENT NO. ______. Amend House Bill 542 by replacing
3 everything after the enacting clause with the following:

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

6 (30 ILCS 775/25)
7 Sec. 25. Medical research and development challenge
8 program.
9 (a) The State shall provide the following financial
10 incentives to draw private and federal funding for biomedical
11 research, technology and programmatic development:
12 (1) Each qualified Chicago Medicare Metropolitan
13 Statistical Area academic medical center hospital shall
14 receive a percentage of the amount available for
15 distribution from the National Institutes of Health
16 Account, equal to that hospital's percentage of the total

1 contracts and grants from the National Institutes of Health
2 awarded to qualified Chicago Medicare Metropolitan
3 Statistical Area academic medical center hospitals and
4 their affiliated medical schools during the preceding
5 calendar year. These amounts shall be paid from the
6 National Institutes of Health Account.
7 (2) Each qualified Chicago Medicare Metropolitan
8 Statistical Area academic medical center hospital shall
9 receive a payment from the State equal to 25% of all funded
10 grants (other than grants funded by the State of Illinois
11 or the National Institutes of Health) for biomedical
12 research, technology, or programmatic development received
13 by that qualified Chicago Medicare Metropolitan
14 Statistical Area academic medical center hospital during
15 the preceding calendar year. These amounts shall be paid
16 from the Philanthropic Medical Research Account.
17 (3) Each qualified Chicago Medicare Metropolitan
18 Statistical Area academic medical center hospital that (i)
19 contributes 40% of the funding for a biomedical research or
20 technology project or a programmatic development project
21 and (ii) obtains contributions from the private sector
22 equal to 40% of the funding for the project shall receive
23 from the State an amount equal to 20% of the funding for
24 the project upon submission of documentation demonstrating
25 those facts to the Comptroller; however, the State shall
26 not be required to make the payment unless the contribution

1 of the qualified Chicago Medicare Metropolitan Statistical
2 Area academic medical center hospital exceeds $100,000.
3 The documentation must be submitted within 180 days of the
4 beginning of the fiscal year. These amounts shall be paid
5 from the Market Medical Research Account.
6 (b) No hospital under the Medical Research and Development
7 Challenge Program shall receive more than 20% of the total
8 amount appropriated to the Medical Research and Development
9 Fund.
10 The amounts received under the Medical Research and
11 Development Challenge Program by the Southern Illinois
12 University School of Medicine in Springfield and its affiliated
13 primary teaching hospitals, considered as a single entity,
14 shall not exceed an amount equal to one-sixth of the total
15 amount available for distribution from the Medical Research and
16 Development Fund, multiplied by a fraction, the numerator of
17 which is the amount awarded the Southern Illinois University
18 School of Medicine and its affiliated teaching hospitals in
19 grants or contracts by the National Institutes of Health and
20 the denominator of which is $8,000,000.
21 (c) On or after the 180th day of the fiscal year the
22 Comptroller may transfer unexpended funds in any account of the
23 Medical Research and Development Fund to pay appropriate claims
24 against another account.
25 (d) The amounts due each qualified Chicago Medicare
26 Metropolitan Statistical Area academic medical center hospital

1 under the Medical Research and Development Fund from the
2 National Institutes of Health Account, the Philanthropic
3 Medical Research Account, and the Market Medical Research
4 Account shall be combined and one quarter of the amount payable
5 to each qualified Chicago Medicare Metropolitan Statistical
6 Area academic medical center hospital shall be paid on the
7 fifteenth working day after July 1, October 1, January 1, and
8 March 1 or on a schedule determined by the Department of
9 Healthcare and Family Services by rule that results in a more
10 expeditious payment of the amounts due.

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

17 (f) In each State fiscal year, beginning in fiscal year
18 2008, the full amount appropriated for the Medical research and
19 development challenge program for that fiscal year shall be
20 distributed as described in this Section.

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

22 (30 ILCS 775/30)

23 Sec. 30. Post-Tertiary Clinical Services Program. The
24 State shall provide incentives to develop and enhance
25 post-tertiary clinical services. Qualified academic medical

1 center hospitals as defined in Section 15 may receive funding
2 under the Post-Tertiary Clinical Services Program for up to 3
3 qualified programs as defined in Section 15 in any given year;
4 however, qualified academic medical center hospitals may
5 receive continued funding for previously funded qualified
6 programs rather than receive funding for a new program so long
7 as the number of qualified programs receiving funding does not
8 exceed 3. Each qualified academic medical center hospital as
9 defined in Section 15 shall receive an equal percentage of the
10 Post-Tertiary Clinical Services Fund to be used in the funding
11 of qualified programs. In each State fiscal year, beginning in
12 fiscal year 2008, the full amount appropriated for the
13 Post-Tertiary Clinical Services Program for that fiscal year
14 shall be distributed as described in this Section. One quarter
15 of the amount payable to each qualified academic medical center
16 hospital shall be paid on the fifteenth working day after July
17 1, October 1, January 1, and March 1 <u>or on a schedule</u>
18 <u>determined by the Department of Healthcare and Family Services</u>
19 <u>by rule that results in a more expeditious payment of the</u>
20 <u>amounts due</u>.
21 (Source: P.A. 95-744, eff. 7-18-08.)

22 (30 ILCS 775/35)
23 Sec. 35. Independent Academic Medical Center Program.
24 There is created an Independent Academic Medical Center Program
25 to provide incentives to develop and enhance the independent

1 academic medical center hospital. In each State fiscal year,
2 beginning in fiscal year 2002, the independent academic medical
3 center hospital shall receive funding under the Program, equal
4 to the full amount appropriated for that purpose for that
5 fiscal year. In each fiscal year, one quarter of the amount
6 payable to the independent academic medical center hospital
7 shall be paid on the fifteenth working day after July 1,
8 October 1, January 1, and March 1 or on a schedule determined
9 by the Department of Healthcare and Family Services by rule
10 that results in a more expeditious payment of the amounts due.
11 (Source: P.A. 92-10, eff. 6-11-01.)

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

15 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)
16 Sec. 5A-4. Payment of assessment; penalty.
17 (a) The annual assessment imposed by Section 5A-2 for State
18 fiscal year 2004 shall be due and payable on June 18 of the
19 year. The assessment imposed by Section 5A-2 for State fiscal
20 year 2005 shall be due and payable in quarterly installments,
21 each equalling one-fourth of the assessment for the year, on
22 July 19, October 19, January 18, and April 19 of the year. The
23 assessment imposed by Section 5A-2 for State fiscal years 2006
24 through 2008 shall be due and payable in quarterly

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

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

1 imposed by Section 5A-2 a penalty assessment equal to the
2 lesser of (i) 5% of the amount of the installment not paid on
3 or before the due date plus 5% of the portion thereof remaining
4 unpaid on the last day of each 30-day period thereafter or (ii)
5 100% of the installment amount not paid on or before the due
6 date. For purposes of this subsection, payments will be
7 credited first to unpaid installment amounts (rather than to
8 penalty or interest), beginning with the most delinquent
9 installments.
10 (d) Any assessment amount that is due and payable to the
11 Illinois Department more frequently than once per calendar
12 quarter shall be remitted to the Illinois Department by the
13 hospital provider by means of electronic funds transfer. The
14 Illinois Department may provide for remittance by other means
15 if (i) the amount due is less than $10,000 or (ii) electronic
16 funds transfer is unavailable for this purpose.
17 (Source: P.A. 94-242, eff. 7-18-05; 95-331, eff. 8-21-07;
18 95-859, eff. 8-19-08.)

19 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)
20 Sec. 5A-8. Hospital Provider Fund.
21 (a) There is created in the State Treasury the Hospital
22 Provider Fund. Interest earned by the Fund shall be credited to
23 the Fund. The Fund shall not be used to replace any moneys
24 appropriated to the Medicaid program by the General Assembly.
25 (b) The Fund is created for the purpose of receiving moneys

1 in accordance with Section 5A-6 and disbursing moneys only for
2 the following purposes, notwithstanding any other provision of
3 law:

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

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

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

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

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

26 (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

1 Medicaid Trust Fund $20,000,000
2 Long-Term Care Provider Fund $30,000,000
3 General Revenue Fund .... $80,000,000.
4 Transfers under this paragraph shall be made within 7
5 days after the payments have been received pursuant to the
6 schedule of payments provided in subsection (a) of Section
7 5A-4.
8 (7.8) For State fiscal year 2008, for making transfers
9 of the moneys received from hospital providers under
10 Section 5A-4 and transferred into the Hospital Provider
11 Fund under Section 5A-6 to the designated funds not
12 exceeding the following amounts in that State fiscal year:
13 Health and Human Services
14 Medicaid Trust Fund $40,000,000
15 Long-Term Care Provider Fund $60,000,000
16 General Revenue Fund .... $160,000,000.
17 Transfers under this paragraph shall be made within 7
18 days after the payments have been received pursuant to the
19 schedule of payments provided in subsection (a) of Section
20 5A-4.
21 (7.9) For State fiscal years 2009 through 2013, for
22 making transfers of the moneys received from hospital
23 providers under Section 5A-4 and transferred into the
24 Hospital Provider Fund under Section 5A-6 to the designated
25 funds not exceeding the following amounts in that State
26 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

1 Department that are attributable to moneys deposited in the
2 Fund.
3 (3) Any interest or penalty levied in conjunction with
4 the administration of this Article.
5 (4) Moneys transferred from another fund in the State
6 treasury.
7 (5) All other moneys received for the Fund from any
8 other source, including interest earned thereon.
9 (d) (Blank).
10 (Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3,
11 eff. 2-27-09; 96-45, eff. 7-15-09.)

12 (305 ILCS 5/5A-12.2)
13 (Section scheduled to be repealed on July 1, 2013)
14 Sec. 5A-12.2. Hospital access payments on or after July 1,
15 2008.
16 (a) To preserve and improve access to hospital services,
17 for hospital services rendered on or after July 1, 2008, the
18 Illinois Department shall, except for hospitals described in
19 subsection (b) of Section 5A-3, make payments to hospitals as
20 set forth in this Section. These payments shall be paid in 12
21 equal installments on or before the seventh State business day
22 of each month, except that no payment shall be due within 100
23 days after the later of the date of notification of federal
24 approval of the payment methodologies required under this
25 Section or any waiver required under 42 CFR 433.68, at which

1 time the sum of amounts required under this Section prior to
2 the date of notification is due and payable. Payments under
3 this Section are not due and payable, however, until (i) the
4 methodologies described in this Section are approved by the
5 federal government in an appropriate State Plan amendment and
6 (ii) the assessment imposed under this Article is determined to
7 be a permissible tax under Title XIX of the Social Security
8 Act.
9 (a-5) The Illinois Department may, when practicable,
10 accelerate the schedule upon which payments authorized under
11 this Section are made.
12 (b) Across-the-board inpatient adjustment.
13 (1) In addition to rates paid for inpatient hospital
14 services, the Department shall pay to each Illinois general
15 acute care hospital an amount equal to 40% of the total
16 base inpatient payments paid to the hospital for services
17 provided in State fiscal year 2005.
18 (2) In addition to rates paid for inpatient hospital
19 services, the Department shall pay to each freestanding
20 Illinois specialty care hospital as defined in 89 Ill. Adm.
21 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
22 the total base inpatient payments paid to the hospital for
23 services provided in State fiscal year 2005.
24 (3) In addition to rates paid for inpatient hospital
25 services, the Department shall pay to each freestanding
26 Illinois rehabilitation or psychiatric hospital an amount

1 equal to $1,000 per Medicaid inpatient day multiplied by
2 the increase in the hospital's Medicaid inpatient
3 utilization ratio (determined using the positive
4 percentage change from the rate year 2005 Medicaid
5 inpatient utilization ratio to the rate year 2007 Medicaid
6 inpatient utilization ratio, as calculated by the
7 Department for the disproportionate share determination).
8 (4) In addition to rates paid for inpatient hospital
9 services, the Department shall pay to each Illinois
10 children's hospital an amount equal to 20% of the total
11 base inpatient payments paid to the hospital for services
12 provided in State fiscal year 2005 and an additional amount
13 equal to 20% of the base inpatient payments paid to the
14 hospital for psychiatric services provided in State fiscal
15 year 2005.
16 (5) In addition to rates paid for inpatient hospital
17 services, the Department shall pay to each Illinois
18 hospital eligible for a pediatric inpatient adjustment
19 payment under 89 Ill. Adm. Code 148.298, as in effect for
20 State fiscal year 2007, a supplemental pediatric inpatient
21 adjustment payment equal to:
22 (i) For freestanding children's hospitals as
23 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
24 multiplied by the hospital's pediatric inpatient
25 adjustment payment required under 89 Ill. Adm. Code
26 148.298, as in effect for State fiscal year 2008.

1 (ii) For hospitals other than freestanding
2 children's hospitals as defined in 89 Ill. Adm. Code
3 149.50(c)(3)(B), 1.0 multiplied by the hospital's
4 pediatric inpatient adjustment payment required under
5 89 Ill. Adm. Code 148.298, as in effect for State
6 fiscal year 2008.
7 (c) Outpatient adjustment.
8 (1) In addition to the rates paid for outpatient
9 hospital services, the Department shall pay each Illinois
10 hospital an amount equal to 2.2 multiplied by the
11 hospital's ambulatory procedure listing payments for
12 categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code
13 148.140(b), for State fiscal year 2005.
14 (2) In addition to the rates paid for outpatient
15 hospital services, the Department shall pay each Illinois
16 freestanding psychiatric hospital an amount equal to 3.25
17 multiplied by the hospital's ambulatory procedure listing
18 payments for category 5b, as defined in 89 Ill. Adm. Code
19 148.140(b)(1)(E), for State fiscal year 2005.
20 (d) Medicaid high volume adjustment. In addition to rates
21 paid for inpatient hospital services, the Department shall pay
22 to each Illinois general acute care hospital that provided more
23 than 20,500 Medicaid inpatient days of care in State fiscal
24 year 2005 amounts as follows:
25 (1) For hospitals with a case mix index equal to or
26 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

1 between the capital costs at the 75th percentile of the
2 capital costs of all Illinois hospitals and the hospital's
3 capital costs.
4 (f) Obstetrical care adjustment.
5 (1) In addition to rates paid for inpatient hospital
6 services, the Department shall pay $1,500 for each Medicaid
7 obstetrical day of care provided in State fiscal year 2005
8 by each Illinois rural hospital that had a Medicaid
9 obstetrical percentage (Medicaid obstetrical days divided
10 by Medicaid inpatient days) greater than 15% for State
11 fiscal year 2005.
12 (2) In addition to rates paid for inpatient hospital
13 services, the Department shall pay $1,350 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 III perinatal center as of December 31,
17 2006, and that had a case mix index equal to or greater
18 than the 45th percentile of the case mix indices for all
19 level III perinatal centers.
20 (3) In addition to rates paid for inpatient hospital
21 services, the Department shall pay $900 for each Medicaid
22 obstetrical day of care provided in State fiscal year 2005
23 by each Illinois general acute care hospital that was
24 designated a level II or II+ perinatal center as of
25 December 31, 2006, and that had a case mix index equal to
26 or greater than the 35th percentile of the case mix indices

1 for all level II and II+ perinatal centers.
2 (g) Trauma adjustment.
3 (1) In addition to rates paid for inpatient hospital
4 services, the Department shall pay each Illinois general
5 acute care hospital designated as a trauma center as of
6 July 1, 2007, a payment equal to 3.75 multiplied by the
7 hospital's State fiscal year 2005 Medicaid capital
8 payments.
9 (2) In addition to rates paid for inpatient hospital
10 services, the Department shall pay $400 for each Medicaid
11 acute inpatient day of care provided in State fiscal year
12 2005 by each Illinois general acute care hospital that was
13 designated a level II trauma center, as defined in 89 Ill.
14 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,
15 2007.
16 (3) In addition to rates paid for inpatient hospital
17 services, the Department shall pay $235 for each Illinois
18 Medicaid acute inpatient day of care provided in State
19 fiscal year 2005 by each level I pediatric trauma center
20 located outside of Illinois that had more than 8,000
21 Illinois Medicaid inpatient days in State fiscal year 2005.
22 (h) Supplemental tertiary care adjustment. In addition to
23 rates paid for inpatient services, the Department shall pay to
24 each Illinois hospital eligible for tertiary care adjustment
25 payments under 89 Ill. Adm. Code 148.296, as in effect for
26 State fiscal year 2007, a supplemental tertiary care adjustment

1 payment equal to the tertiary care adjustment payment required
2 under 89 Ill. Adm. Code 148.296, as in effect for State fiscal
3 year 2007.

4 (i) Crossover adjustment. In addition to rates paid for
5 inpatient services, the Department shall pay each Illinois
6 general acute care hospital that had a ratio of crossover days
7 to total inpatient days for medical assistance programs
8 administered by the Department (utilizing information from
9 2005 paid claims) greater than 50%, and a case mix index
10 greater than the 65th percentile of case mix indices for all
11 Illinois hospitals, a rate of $1,125 for each Medicaid
12 inpatient day including crossover days.

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

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

26 (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

1 unless provided otherwise in this Section, the terms used in
2 this Section for qualifying criteria and payment calculations
3 shall have the same meanings as those terms have been given in
4 the Illinois Department's administrative rules as in effect on
5 March 1, 2008. Other terms shall be defined by the Illinois
6 Department by rule.

7 As used in this Section, unless the context requires
8 otherwise:

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

17 "Capital costs" means, for a given hospital, the total
18 capital costs determined using the most recent 2005 Medicare
19 cost report as contained in the Healthcare Cost Report
20 Information System file, for the quarter ending on December 31,
21 2006, divided by the total inpatient days from the same cost
22 report to calculate a capital cost per day. The resulting
23 capital cost per day is inflated to the midpoint of State
24 fiscal year 2009 utilizing the national hospital market price
25 proxies (DRI) hospital cost index. If a hospital's 2005
26 Medicare cost report is not contained in the Healthcare Cost

1 Report Information System, the Department may obtain the data
2 necessary to compute the hospital's capital costs from any
3 source available, including, but not limited to, records
4 maintained by the hospital provider, which may be inspected at
5 all times during business hours of the day by the Illinois
6 Department or its duly authorized agents and employees.

7 "Case mix index" means, for a given hospital, the sum of
8 the DRG relative weighting factors in effect on January 1,
9 2005, for all general acute care admissions for State fiscal
10 year 2005, excluding Medicare crossover admissions and
11 transplant admissions reimbursed under 89 Ill. Adm. Code
12 148.82, divided by the total number of general acute care
13 admissions for State fiscal year 2005, excluding Medicare
14 crossover admissions and transplant admissions reimbursed
15 under 89 Ill. Adm. Code 148.82.

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

24 "Medicaid obstetrical day" means, for a given hospital, the
25 sum of days of inpatient hospital days grouped by the
26 Department to DRGs of 370 through 375 provided to recipients of

1 medical assistance under Title XIX of the federal Social
2 Security Act, excluding days for individuals eligible for
3 Medicare under Title XVIII of that Act (Medicaid/Medicare
4 crossover days), as tabulated from the Department's paid claims
5 data for admissions occurring during State fiscal year 2005
6 that was adjudicated by the Department through March 23, 2007.

7 "Outpatient ambulatory procedure listing payments" means,
8 for a given hospital, the sum of payments for ambulatory
9 procedure listing services, as described in 89 Ill. Adm. Code
10 148.140(b), provided to recipients of medical assistance under
11 Title XIX of the federal Social Security Act, excluding
12 payments for individuals eligible for Medicare under Title
13 XVIII of the Act (Medicaid/Medicare crossover days), as
14 tabulated from the Department's paid claims data for services
15 occurring in State fiscal year 2005 that were adjudicated by
16 the Department through March 23, 2007.

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

21 (p) Notwithstanding any of the other provisions of this
22 Section, the Department is authorized to adopt rules that
23 change the hospital access improvement payments specified in
24 this Section, but only to the extent necessary to conform to
25 any federally approved amendment to the Title XIX State plan.
26 Any such rules shall be adopted by the Department as authorized

1 by Section 5-50 of the Illinois Administrative Procedure Act.
2 Notwithstanding any other provision of law, any changes
3 implemented as a result of this subsection (p) shall be given
4 retroactive effect so that they shall be deemed to have taken
5 effect as of the effective date of this Section.
6 (q) For State fiscal years 2012 and 2013, the Department
7 may make recommendations to the General Assembly regarding the
8 use of more recent data for purposes of calculating the
9 assessment authorized under Section 5A-2 and the payments
10 authorized under this Section 5A-12.2.
11 (Source: P.A. 95-859, eff. 8-19-08.)

12 (305 ILCS 5/5A-12.3 new)
13 Sec. 5A-12.3. Hospital Medicaid Stimulus Payments.
14 (a) Supplemental payments. Subject to federal approval and
15 as soon as practicable after the effective date of this
16 amendatory Act of the 96th General Assembly, the Department
17 shall make a one-time Medicaid supplemental payment to
18 hospitals for inpatient and outpatient Medicaid services. This
19 payment shall be the sum of the following payment
20 methodologies:
21 (1) In addition to the rates paid for outpatient
22 hospital services, the Department shall pay all rural
23 hospitals a supplemental outpatient payment in an amount
24 equal to the hospital's outpatient ambulatory procedure
25 listing payments for Group 3 as defined in 89 Ill. Adm.

1 Code 148.140(b)(1)(C), for State fiscal year 2005. For a
2 hospital qualified as a critical access hospital, as
3 designated by the Illinois Department of Public Health in
4 accordance with 42 CFR 485, Subpart F (2001), the payment
5 amount under this paragraph (1) shall be multiplied by 3.5.
6 In order to qualify for payments under this Section a
7 hospital must:
8 (A) Be a hospital that is licensed by the
9 Department of Public Health under the Hospital
10 Licensing Act, certified by that Department to
11 participate in the Illinois Medicaid Program, and
12 enrolled with the Department of Healthcare and Family
13 Services to participate in the Illinois Medicaid
14 Program;
15 (B) Provide services as required under 77 Ill. Adm.
16 Code 250.710 in an emergency room subject to the
17 requirements under either 77 Ill. Adm. Code
18 250.2440(k) or 77 Ill. Adm. Code 250.2630(k); and
19 (C) Be a rural Illinois hospital, as defined at 89
20 Ill. Adm. Code 148.25(g)(3).
21 (2) In addition to the rates paid for inpatient
22 hospital services, the Department shall pay $175 for each
23 Medicaid obstetrical day of care by each Illinois general
24 acute care hospital that was designated a level III
25 perinatal center as of July 1, 2009 and provided more than
26 2,000 Medicaid obstetrical days of service.

1 (3) In addition to the rates paid for inpatient
2 hospital services, the Department shall pay $22 for each
3 Medicaid inpatient day to each hospital designated as a
4 Level I Trauma Center. For the purpose of this Section, a
5 Level I Trauma Center is a hospital designated by the
6 Department of Public Health using the criteria under 77
7 Ill. Adm. Code 515.2030 or 77 Ill. Adm. Code 515.2035 as of
8 July 1, 2009. For the purposes of this payment, hospitals
9 located in the same city that alternate their Level I
10 Trauma Center designation as defined in 89 Ill. Adm. Code
11 148.295(a)(2) shall both be eligible to receive this
12 payment.
13 (4) In addition to the rates paid for inpatient
14 hospital services, the Department shall pay $37 for each
15 Medicaid inpatient day.
16 (5) In addition to the rates paid for inpatient
17 hospital services, the Department shall pay an additional
18 $35 for each Medicaid inpatient day to each hospital
19 qualifying for a payment in paragraph (4) of this
20 subsection (a) that also qualifies for payments under 89
21 Ill. Adm. Code 148.120 or 89 Ill. Adm. Code 148.122 for the
22 rate period beginning October 1, 2009.
23 (b) Exclusions from payments under this Section.
24 (1) A hospital that is operated by a State agency, a
25 State university, or a county with a population of
26 3,000,000 or more is not eligible for any payment under

1 this Section.
2 (2) A hospital as defined in 89 Ill. Adm. Code
3 149.50(c)(4) is not eligible for any payment under
4 paragraph (4) or (5) of subsection (a) of this Section.
5 (3) A hospital as defined in 89 Ill. Adm. Code
6 149.50(c)(1) or 89 Ill. Adm. Code 149.50(c)(2) is not
7 eligible for any payment under paragraph (5) of subsection
8 (a) of this Section.
9 (4) A hospital that ceases operations prior to federal
10 approval of, and adoption of administrative rules
11 necessary to effect, payments under this Section is not
12 eligible for any payment under this Section.
13 (5) A hospital that has filed for bankruptcy or is
14 operating under bankruptcy protection under any Chapter of
15 Title 11 of the United States Code (Bankruptcy) is not
16 eligible for any payment under this Section.
17 (c) Definitions. Unless the context requires otherwise or
18 unless provided otherwise in this Section, the terms used in
19 this Section for qualifying criteria and payment calculations
20 shall have the same meanings as those terms have been given in
21 the Department's administrative rules as in effect on March 1,
22 2008. As used in this Section, unless the context requires
23 otherwise:
24 (1) "Medicaid inpatient day" has the same meaning as
25 defined in subsection (n) of Section 5A-12.2.
26 (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.

1 (c) Section 5A-12.1 is repealed on July 1, 2008.
2 (d) Section 5A-12.2 is repealed on July 1, 2013.
3 (e) Section 5A-12.3 is repealed on July 1, 2011.
4 (Source: P.A. 94-242, eff. 7-18-05; 95-859, eff. 8-19-08.)

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