HB5746

LRB09718814KTG65663b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB5746

Introduced 2/16/2012, by Rep. Camille Y Lilly

SYNOPSIS AS INTRODUCED:

See Index

Amend the Hospital Provider Funding Article of the Illinois Public Aid Code. Imposes specific assessments on outpatient services for State fiscal years 2012 through 2014. Provides that no installment payment of an assessment shall be due and payable until after: (i) the Department of Healthcare and Family Services notifies the hospital provider, in writing, that certain payment methodologies to hospitals required under the Article have been approved by the Centers for Medicare and Medicaid Services and a specified federal waiver has been granted by the Centers for Medicare and Medicaid Services; and (ii) the Comptroller has issued the payments required under the Article. Requires certain money transfers from the Hospital Provider Fund for State fiscal years 2012, 2013, and 2014. Provides that the new assessments shall not take effect or shall cease to be imposed if certain criteria are met. Contains provisions concerning hospital access improvement payments on or after January 1, 2012; magnet and perinatal hospital adjustments; trauma level II adjustments; dual eligible adjustments; medicaid volume adjustments; outpatient service adjustments; care coordination adjustments; specialty hospital adjustments; and physician supplemental adjustments. Defines terms. Makes other changes. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Sections 5A-1, 5A-2, 5A-4, 5A-5, 5A-8, 5A-10, 5A-13, and 5A-14 and by adding Section 5A-12.4 as follows:

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

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

"Adjusted gross hospital revenue" shall be determined separately for inpatient and outpatient services for each hospital conducted, operated or maintained by a hospital provider, and means the hospital provider's total gross revenues less: (i) gross revenue attributable to non-hospital based services including home dialysis services, durable medical equipment, ambulance services, outpatient clinics and any other non-hospital based services as determined by the Illinois Department by rule; and (ii) gross revenues attributable to the routine services provided to persons receiving skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act; and (iii) Medicare gross revenue (excluding the Medicare gross revenue attributable to clauses (i) and (ii) of this

paragraph and the Medicare gross revenue attributable to the routine services provided to patients in a psychiatric hospital, a rehabilitation hospital, a distinct part psychiatric unit, a distinct part rehabilitation unit, or swing beds). Adjusted gross hospital revenue shall be determined using the most recent data available from each hospital's 2003 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2004, without regard to any subsequent adjustments or changes to such data. If a hospital's 2003 Medicare cost report is not contained in the Healthcare Cost Report Information System, the hospital provider shall furnish such cost report or the data necessary to determine its adjusted gross hospital revenue as required by rule by the Illinois Department.

"Fund" means the Hospital Provider Fund.

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

"Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this paragraph, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited

liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

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

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

"Outpatient gross revenue" means, for each hospital, its total gross charges attributed to outpatient services as reported on the Medicare cost report at Worksheet C, Part I, Column 7, line 101, less the sum of lines 45, 60, 63, 64, 65, 66, 67, and 68 (and any subsets of those lines).

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

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

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

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

Sec. 5A-2. Assessment.

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

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

Subject to Sections 5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning

August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007, and 2008, in an amount equal to 2.5835% of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835% of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Illinois Department may obtain the hospital provider's adjusted gross hospital revenue 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.

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

For State fiscal years 2009 through 2014, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System,

then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

(b) (Blank).

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

For State fiscal years 2012 through 2014, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue 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 Department or its duly authorized agents and employees.

(c) (Blank).

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

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become

effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

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

(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 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.

Except as provided in subsection (a-5) of this Section, the assessment imposed by subsection (b-5) of Section 5A-2 for

State fiscal year 2012 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 14th State business day of each month. No installment payment of an assessment imposed by subsection (b-5) of 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-12.4, 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 subsection (b-5) of Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12.4. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.4 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b-5) of Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.4.

(a-5) The Illinois Department may~~, 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 or Section 5A-12.4 to the same hospitals. For the purposes of this subsection (a-5), a hospital's payment ratio is defined as the quotient obtained by dividing the total payments for the State fiscal year, as authorized under Section 5A-12.2 or Section 5A-12.4, by the total assessment for the State fiscal year imposed under Section 5A-2 or subsection (b-5) of Section 5A-2.

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

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

penalty or interest), beginning with the most delinquent installments.

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

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

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

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

(a) The Department of Healthcare and Family Services shall send a notice of assessment to every hospital provider subject to assessment under this Article. The notice of assessment shall notify the hospital of its assessment and shall be sent after receipt by the Department of notification from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services that the payment methodologies required under Section 5A-12, Section 5A-12.1, or Section 5A-12.2, <u>or Section 5A-12.4,</u> whichever is applicable for that fiscal year, and, if necessary, the waiver granted under 42 CFR 433.68 have been approved. The notice shall be on a form prepared by the Illinois Department and shall state the

following:

(1) The name of the hospital provider.

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

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

(4) (Blank).

(5) Other reasonable information as determined by the Illinois Department.

(b) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, the provider shall pay the assessment for each hospital separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to conduct, operate, or maintain a hospital in respect of which the person is subject to assessment under this Article as a hospital provider, the assessment for the State fiscal year in which the cessation

occurs shall be adjusted by multiplying the assessment computed under Section 5A-2 by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate, or maintain a hospital, the person shall pay the assessment for the year as so adjusted (to the extent not previously paid).

(d) Notwithstanding any other provision in this Article, a provider who commences conducting, operating, or maintaining a hospital, upon notice by the Illinois Department, shall pay the assessment computed under Section 5A-2 and subsection (e) in installments on the due dates stated in the notice and on the regular installment due dates for the State fiscal year occurring after the due dates of the initial notice.

(e) Notwithstanding any other provision in this Article, for State fiscal years 2004 and 2005, in the case of a hospital provider that did not conduct, operate, or maintain a hospital throughout calendar year 2001, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for State fiscal years 2006 through 2008, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2003, the assessment for that State fiscal year shall be computed on the basis of hypothetical adjusted gross hospital revenue for the hospital's first full

fiscal year as determined by the Illinois Department (which may be based on annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior provider of the same hospital during the year). Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2014, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for State fiscal years 2012 through 2014, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2009, the assessment under subsection (b-5) of Section 5A-2 for that State fiscal year shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Illinois Department.

(f) Every hospital provider subject to assessment under this Article shall keep sufficient records to permit the determination of adjusted gross hospital revenue for the hospital's fiscal year. All such records shall be kept in the English language and shall, at all times during regular business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

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

(h) (Blank).

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

(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, 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 2014, 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.

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

Health Care Provider Relief Fund $10,000,000

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

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

Health Care Provider Relief Fund $20,000,000

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.

(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; 96-821, eff. 11-20-09;

96-1530, eff. 2-16-11.)

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

Sec. 5A-10. Applicability.

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

(1) The sum of the appropriations for State fiscal years 2004 and 2005 from the General Revenue Fund for hospital payments under the medical assistance program is less than $4,500,000,000 or the appropriation for each of State fiscal years 2006, 2007 and 2008 from the General Revenue Fund for hospital payments under the medical assistance program is less than $2,500,000,000 increased annually to reflect any increase in the number of recipients, or the annual appropriation for State fiscal years 2009, 2010, 2011, 2013, and 2014, from the General Revenue Fund combined with the Hospital Provider Fund as authorized in Section 5A-8 for hospital payments under the medical assistance program, is less than the amount appropriated for State fiscal year 2009, adjusted annually to reflect any change in the number of recipients, excluding State fiscal year 2009 supplemental appropriations made necessary by the enactment of the American Recovery and Reinvestment Act of 2009; or

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

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

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

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

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

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

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

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund derived from assessments imposed prior thereto shall be disbursed in accordance with Section 5A-8 to the extent federal financial participation is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(c) The assessments imposed by subsection (b-5) of Section 5A-2 shall not take effect or shall cease to be imposed, and any moneys remaining in the Fund shall be refunded to hospital

providers in proportion to the amounts paid by them, if the payments to hospitals required under Section 5A-12.4 are changed, unless the change is pursuant to subsection (p) of Section 5A-12.4 or are not eligible for federal matching funds under Title XIX of the Social Security Act.

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

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

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

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

(Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72,

eff. 7-1-11; 97-74, eff. 6-30-11.)

(305 ILCS 5/5A-12.4 new)

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

(a) Hospital access improvement payments. To preserve and improve access to hospital services, for hospital and physician services rendered on or after January 1, 2012, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the 7th State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under subsection (b-5) of Section 5A-2 of this Article is determined to be a permissible tax under Title XIX of the Social Security Act. For State fiscal year 2013, the amount of the payments shall be prorated based on the portion of the fiscal year for which they and the assessment authorized

under subsection (b-5) of Section 5A-2 are in effect.

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

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

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

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

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

(1) For hospitals with a case mix index equal to or greater than the 50th percentile of case mix indices for

all Illinois hospitals, $380 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

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

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

(d) Dual eligible 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 programs under Title XIX of the Social Security Act administered by the Department (utilizing information from 2009 paid claims) greater than 50%, and a case mix index equal to or greater than the 75th percentile of case mix indices for all Illinois hospitals, a rate of $380 for each Medicaid inpatient day during State fiscal year 2009 including crossover days.

(e) Medicaid 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 10,000 Medicaid inpatient days of care in State fiscal year 2009, has a Medicaid inpatient utilization rate of at

least 29.05% as calculated by the Department for the Rate Year 2011 Disproportionate Share determination, and is not eligible for Medicaid Percentage Adjustment payments in rate year 2012 an amount equal to $75 for each Medicaid inpatient day of care provided during State fiscal year 2009.

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

(g) Care coordination adjustment.

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

(2) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding psychiatric hospital an amount equal to $100 multiplied by the hospital's ambulatory procedure listing services for category 5A for State fiscal year 2009.

(3) In order to incentivize better coordination of care for patients receiving emergency room services and

services related to behavioral health and substance abuse, the Department may seek to have the care coordination activities that are developed in consultation with a statewide association representing hospitals and that are supported by these adjustment payments considered under Section 2703 of the Affordable Care Act.

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

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

(1) Physician services eligible for the adjustment payment are those provided by physicians employed by or who have an exclusive contract to provide services to patients of the following hospitals: (i) Illinois general acute care hospitals that provided at least 17,000 Medicaid inpatient days of care in State fiscal year 2009 and had a Medicaid inpatient utilization rate of at least 19.23% as calculated

by the Department for the Rate Year 2011 Disproportionate Share determination; and (ii) Illinois freestanding children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).

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

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

(k) 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.

(l) 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 October 1, 2011. Other terms shall be defined by the Illinois Department by rule.

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

"Case mix index" means, for a given hospital, the sum of the per admission (DRG) relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2009, 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 2009, 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 2009 that was adjudicated by the Department through June 30, 2010.

"Outpatient ambulatory procedure listing services" means, for a given hospital, 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 services for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in State fiscal year 2009 that were adjudicated by the Department through September 2, 2010.

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

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

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

(o) The Department of Healthcare and Family Services must submit a State Medicaid Plan Amendment to the Centers of Medicare and Medicaid Services to implement the payments under this Section within 30 days of the effective date of this amendatory Act of the 97th General Assembly.

(p) If any of the federal upper payment limits applicable to the payments under this Section are exceeded due to an expansion of the number of recipients enrolled in fully-capitated, risk-based managed care arrangements prior to the dates set forth in subsections (a) and (d) of Section 5A-14, the payments under this Section that exceed the

applicable federal upper payment limits may be reduced uniformly to the extent necessary to comply with the applicable federal upper payment limit.

(305 ILCS 5/5A-13)

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

The Department of Healthcare and Family Services may adopt rules necessary to implement this amendatory Act of the 97th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 97th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

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

(305 ILCS 5/5A-14)

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

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

(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 and Section 5A-12.4 are ~~is~~ repealed on July 1, 2014.

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

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

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

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