AN ACT concerning State government.

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

Section 5. The Illinois Administrative Procedure Act is amended by changing Section 5-45 as follows:

(5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

Sec. 5-45. Emergency rulemaking.

(a) "Emergency" means the existence of any situation that any agency finds reasonably constitutes a threat to the public interest, safety, or welfare.

(b) If any agency finds that an emergency exists that requires adoption of a rule upon fewer days than is required by Section 5-40 and states in writing its reasons for that finding, the agency may adopt an emergency rule without prior notice or hearing upon filing a notice of emergency rulemaking with the Secretary of State under Section 5-70. The notice shall include the text of the emergency rule and shall be published in the Illinois Register. Consent orders or other court orders adopting settlements negotiated by an agency may be adopted under this Section. Subject to applicable constitutional or statutory provisions, an emergency rule becomes effective immediately upon filing under Section 5-65 or at a stated date less than 10 days thereafter. The agency's

finding and a statement of the specific reasons for the finding shall be filed with the rule. The agency shall take reasonable and appropriate measures to make emergency rules known to the persons who may be affected by them.

(c) An emergency rule may be effective for a period of not longer than 150 days, but the agency's authority to adopt an identical rule under Section 5-40 is not precluded. No emergency rule may be adopted more than once in any 24 month period, except that this limitation on the number of emergency rules that may be adopted in a 24 month period does not apply to (i) emergency rules that make additions to and deletions from the Drug Manual under Section 5-5.16 of the Illinois Public Aid Code or the generic drug formulary under Section 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act, (iii) emergency rules adopted by the Illinois Department of Public Health under subsections (a) through (i) of Section 2 of the Department of Public Health Act when necessary to protect the public's health, (iv) emergency rules adopted pursuant to subsection (n) of this Section, (v) emergency rules adopted pursuant to subsection (o) of this Section, or (vi) emergency rules adopted pursuant to subsection (c-5) of this Section. Two or more emergency rules having substantially the same purpose and effect shall be deemed to be a single rule for purposes of this Section.

(c-5) To facilitate the maintenance of the program of group health benefits provided to annuitants, survivors, and retired employees under the State Employees Group Insurance Act of 1971, rules to alter the contributions to be paid by the State, annuitants, survivors, retired employees, or any combination of those entities, for that program of group health benefits, shall be adopted as emergency rules. The adoption of those rules shall be considered an emergency and necessary for the public interest, safety, and welfare.

(d) In order to provide for the expeditious and timely implementation of the State's fiscal year 1999 budget, emergency rules to implement any provision of Public Act 90-587 or 90-588 or any other budget initiative for fiscal year 1999 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

(e) In order to provide for the expeditious and timely implementation of the State's fiscal year 2000 budget, emergency rules to implement any provision of Public Act 91-24 ~~this amendatory Act of the 91st General Assembly~~ or any other budget initiative for fiscal year 2000 may be adopted in

accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (e). The adoption of emergency rules authorized by this subsection (e) shall be deemed to be necessary for the public interest, safety, and welfare.

(f) In order to provide for the expeditious and timely implementation of the State's fiscal year 2001 budget, emergency rules to implement any provision of Public Act 91-712 ~~this amendatory Act of the 91st General Assembly~~ or any other budget initiative for fiscal year 2001 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (f). The adoption of emergency rules authorized by this subsection (f) shall be deemed to be necessary for the public interest, safety, and welfare.

(g) In order to provide for the expeditious and timely implementation of the State's fiscal year 2002 budget, emergency rules to implement any provision of Public Act 92-10 ~~this amendatory Act of the 92nd General Assembly~~ or any other budget initiative for fiscal year 2002 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the

24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (g). The adoption of emergency rules authorized by this subsection (g) shall be deemed to be necessary for the public interest, safety, and welfare.

(h) In order to provide for the expeditious and timely implementation of the State's fiscal year 2003 budget, emergency rules to implement any provision of Public Act 92-597 ~~this amendatory Act of the 92nd General Assembly~~ or any other budget initiative for fiscal year 2003 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (h). The adoption of emergency rules authorized by this subsection (h) shall be deemed to be necessary for the public interest, safety, and welfare.

(i) In order to provide for the expeditious and timely implementation of the State's fiscal year 2004 budget, emergency rules to implement any provision of Public Act 93-20 ~~this amendatory Act of the 93rd General Assembly~~ or any other budget initiative for fiscal year 2004 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules

adopted under this subsection (i). The adoption of emergency rules authorized by this subsection (i) shall be deemed to be necessary for the public interest, safety, and welfare.

(j) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2005 budget as provided under the Fiscal Year 2005 Budget Implementation (Human Services) Act, emergency rules to implement any provision of the Fiscal Year 2005 Budget Implementation (Human Services) Act may be adopted in accordance with this Section by the agency charged with administering that provision, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (j). The Department of Public Aid may also adopt rules under this subsection (j) necessary to administer the Illinois Public Aid Code and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (j) shall be deemed to be necessary for the public interest, safety, and welfare.

(k) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2006 budget, emergency rules to implement any provision of Public Act 94-48 ~~this amendatory Act of the 94th General Assembly~~ or any other budget initiative for fiscal year 2006 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative,

except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (k). The Department of Healthcare and Family Services may also adopt rules under this subsection (k) necessary to administer the Illinois Public Aid Code, the Senior Citizens and Persons with Disabilities Property Tax Relief Act, the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act (now the Illinois Prescription Drug Discount Program Act), and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (k) shall be deemed to be necessary for the public interest, safety, and welfare.

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2007 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2007, including rules effective July 1, 2007, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (l) shall be deemed to be necessary for the public interest, safety, and welfare.

(m) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2008 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2008, including rules effective July 1, 2008, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (m) shall be deemed to be necessary for the public interest, safety, and welfare.

(n) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2010 budget, emergency rules to implement any provision of Public Act 96-45 ~~this amendatory Act of the 96th General Assembly~~ or any other budget initiative authorized by the 96th General Assembly for fiscal year 2010 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (n) shall be deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (n) shall apply only to rules promulgated during Fiscal Year 2010.

(o) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2011 budget, emergency rules to implement any provision of Public Act 96-958 ~~this amendatory Act of the 96th General Assembly~~ or any other budget initiative authorized by the 96th General Assembly for fiscal year 2011 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (o) is deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (o) applies only to rules promulgated on or after the effective date of Public Act 96-958 ~~this amendatory Act of the 96th General Assembly~~ through June 30, 2011.

(p) In order to provide for the expeditious and timely implementation of the provisions of Public Act 97-689, emergency rules to implement any provision of Public Act 97-689 may be adopted in accordance with this subsection (p) by the agency charged with administering that provision or initiative. The 150-day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection (p), and the effective period may continue through June 30, 2013. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (p). The adoption of emergency rules authorized by this subsection (p) is deemed to be necessary for the public

interest, safety, and welfare.

(q) In order to provide for the expeditious and timely implementation of the provisions of Articles 7, 8, 9, 11, and 12 of Public Act 98-104 ~~this amendatory Act of the 98th General Assembly~~, emergency rules to implement any provision of Articles 7, 8, 9, 11, and 12 of Public Act 98-104 ~~this amendatory Act of the 98th General Assembly~~ may be adopted in accordance with this subsection (q) by the agency charged with administering that provision or initiative. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (q). The adoption of emergency rules authorized by this subsection (q) is deemed to be necessary for the public interest, safety, and welfare.

(r) In order to provide for the expeditious and timely implementation of the provisions of Public Act 98-651 ~~this amendatory Act of the 98th General Assembly~~, emergency rules to implement Public Act 98-651 ~~this amendatory Act of the 98th General Assembly~~ may be adopted in accordance with this subsection (r) by the Department of Healthcare and Family Services. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (r). The adoption of emergency rules authorized by this subsection (r) is deemed to be necessary for the public interest, safety, and welfare.

(s) In order to provide for the expeditious and timely implementation of the provisions of Sections 5-5b.1 and 5A-2 of

the Illinois Public Aid Code, emergency rules to implement any provision of Section 5-5b.1 or Section 5A-2 of the Illinois Public Aid Code may be adopted in accordance with this subsection (s) by the Department of Healthcare and Family Services. The rulemaking authority granted in this subsection (s) shall apply only to those rules adopted prior to July 1, 2015. Notwithstanding any other provision of this Section, any emergency rule adopted under this subsection (s) shall only apply to payments made for State fiscal year 2015. The adoption of emergency rules authorized by this subsection (s) is deemed to be necessary for the public interest, safety, and welfare.

(t) In order to provide for the expeditious and timely implementation of the provisions of Article II of Public Act 99-6 ~~this amendatory Act of the 99th General Assembly~~, emergency rules to implement the changes made by Article II of Public Act 99-6 ~~this amendatory Act of the 99th General Assembly~~ to the Emergency Telephone System Act may be adopted in accordance with this subsection (t) by the Department of State Police. The rulemaking authority granted in this subsection (t) shall apply only to those rules adopted prior to July 1, 2016. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (t). The adoption of emergency rules authorized by this subsection (t) is deemed to be necessary for the public interest, safety, and welfare.

(u) ~~(t)~~ In order to provide for the expeditious and timely

implementation of the provisions of the Burn Victims Relief Act, emergency rules to implement any provision of the Act may be adopted in accordance with this subsection (u) ~~(t)~~ by the Department of Insurance. The rulemaking authority granted in this subsection (u) ~~(t)~~ shall apply only to those rules adopted prior to December 31, 2015. The adoption of emergency rules authorized by this subsection (u) ~~(t)~~ is deemed to be necessary for the public interest, safety, and welfare.

(v) In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 99th General Assembly, emergency rules to implement this amendatory Act of the 99th General Assembly may be adopted in accordance with this subsection (v) by the Department of Healthcare and Family Services. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (v). The adoption of emergency rules authorized by this subsection (v) is deemed to be necessary for the public interest, safety, and welfare.

(Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 99-2, eff. 3-26-15; 99-6, eff. 1-1-16; 99-143, eff. 7-27-15; 99-455, eff. 1-1-16; revised 10-15-15.)

Section 10. The State Finance Act is amended by changing Section 6z-81 as follows:

(30 ILCS 105/6z-81)

Sec. 6z-81. Healthcare Provider Relief Fund.

(a) There is created in the State treasury a special fund to be known as the Healthcare Provider Relief Fund.

(b) The Fund is created for the purpose of receiving and disbursing moneys in accordance with this Section. Disbursements from the Fund shall be made only as follows:

(1) Subject to appropriation, for payment by the Department of Healthcare and Family Services or by the Department of Human Services of medical bills and related expenses, including administrative expenses, for which the State is responsible under Titles XIX and XXI of the Social Security Act, the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, and the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

(2) For repayment of funds borrowed from other State funds or from outside sources, including interest thereon.

(3) For State fiscal years 2017 and 2018, for making payments to the human poison control center pursuant to Section 12-4.105 of the Illinois Public Aid Code.

(c) The Fund shall consist of the following:

(1) Moneys received by the State from short-term borrowing pursuant to the Short Term Borrowing Act on or after the effective date of this amendatory Act of the 96th General Assembly.

(2) All federal matching funds received by the Illinois

Department of Healthcare and Family Services as a result of expenditures made by the Department that are attributable to moneys deposited in the Fund.

(3) All federal matching funds received by the Illinois Department of Healthcare and Family Services as a result of federal approval of Title XIX State plan amendment transmittal number 07-09.

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

(5) All federal matching funds received by the Illinois Department of Healthcare and Family Services as a result of expenditures made by the Department for Medical Assistance from the General Revenue Fund, the Tobacco Settlement Recovery Fund, the Long-Term Care Provider Fund, and the Drug Rebate Fund related to individuals eligible for medical assistance pursuant to the Patient Protection and Affordable Care Act (P.L. 111-148) and Section 5-2 of the Illinois Public Aid Code.

(d) In addition to any other transfers that may be provided for by law, on the effective date of this amendatory Act of the 97th General Assembly, or as soon thereafter as practical, the State Comptroller shall direct and the State Treasurer shall transfer the sum of $365,000,000 from the General Revenue Fund into the Healthcare Provider Relief Fund.

(e) In addition to any other transfers that may be provided for by law, on July 1, 2011, or as soon thereafter as

practical, the State Comptroller shall direct and the State Treasurer shall transfer the sum of $160,000,000 from the General Revenue Fund to the Healthcare Provider Relief Fund.

(f) Notwithstanding any other State law to the contrary, and in addition to any other transfers that may be provided for by law, the State Comptroller shall order transferred and the State Treasurer shall transfer $500,000,000 to the Healthcare Provider Relief Fund from the General Revenue Fund in equal monthly installments of $100,000,000, with the first transfer to be made on July 1, 2012, or as soon thereafter as practical, and with each of the remaining transfers to be made on August 1, 2012, September 1, 2012, October 1, 2012, and November 1, 2012, or as soon thereafter as practical. This transfer may assist the Department of Healthcare and Family Services in improving Medical Assistance bill processing timeframes or in meeting the possible requirements of Senate Bill 3397, or other similar legislation, of the 97th General Assembly should it become law.

(g) Notwithstanding any other State law to the contrary, and in addition to any other transfers that may be provided for by law, on July 1, 2013, or as soon thereafter as may be practical, the State Comptroller shall direct and the State Treasurer shall transfer the sum of $601,000,000 from the General Revenue Fund to the Healthcare Provider Relief Fund.

(Source: P.A. 97-44, eff. 6-28-11; 97-641, eff. 12-19-11; 97-689, eff. 6-14-12; 97-732, eff. 6-30-12; 98-24, eff.

6-19-13; 98-463, eff. 8-16-13.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5A-2, 5A-8, 5A-12.2, and 5A-12.5 and by adding Section 12-4.105 as follows:

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

(Section scheduled to be repealed on July 1, 2018)

Sec. 5A-2. Assessment.

(a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, 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, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 5A-12.5 ~~Section 12-5~~, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period of April through June 2015, the amount of $218.38 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, in addition to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

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

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through

2018, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5 ~~Section 12-5~~, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, in addition to any federally required State share as authorized under paragraph (1), the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, 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.

(b-6)(1) As used in this Section, "ACA Assessment Adjustment" means:

(A) For the period of July 1, 2016 through December 31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2016 multiplied by 6.

(B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the

fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subparagraph (B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning July 1, 2016 through December 31, 2016 and the estimated payments due and payable in the month of April 2016 multiplied by 6 as described in subparagraph (A).

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2017 multiplied by 6, except that the amount calculated under this subparagraph (C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning January 1, 2017 through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subparagraph (B).

(D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

(i) the amount calculated under this subparagraph (D) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period of July 1, 2017 through December 31, 2017 and the estimated payments due and payable in the month of April 2017 multiplied by 6 as described in subparagraph (C); and

(ii) the amount calculated under this subparagraph (D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments, if any, estimated to be paid to hospitals under subsection (b) of Section 5A-12.5.

(2) The Department shall complete and apply a final reconciliation of the ACA Assessment Adjustment prior to June 30, 2018 to account for:

(A) any differences between the actual payments issued or scheduled to be issued prior to June 30, 2018 as authorized in Section 5A-12.5 for the period of January 1,

2018 through June 30, 2018 and the estimated payments due and payable in the month of October 2017 multiplied by 6 as described in subparagraph (D); and

(B) any difference between the estimated fee-for-service payments under subsection (b) of Section 5A-12.5 and the amount of such payments that are actually scheduled to be paid.

The Department shall notify hospitals of any additional amounts owed or reduction credits to be applied to the June 2018 ACA Assessment Adjustment. This is to be considered the final reconciliation for the ACA Assessment Adjustment.

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D) of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than

$450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized 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. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

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

Sec. 5A-8. Hospital Provider Fund.

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

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

(1) For making payments to hospitals as required under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and

under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

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

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing activities under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

(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 plus any interest that would have been earned by that fund on the

monies that had been transferred.

(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 making transfers not exceeding the following amounts, related to State fiscal years 2013 through 2018, to the following designated funds:

| | |
|---|---|
| Health and Human Services Medicaid Trust Fund | $20,000,000 |
| Long-Term Care Provider Fund | $30,000,000 |
| General Revenue Fund | $80,000,000. |

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

(7.1) (Blank).

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

(7.10) For State fiscal year 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 .... $100,000,000

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.

The additional amount of transfers in this paragraph (7.10), authorized by Public Act 98-651, shall be made within 10 State business days after June 16, 2014 (the effective date of Public Act 98-651). That authority shall remain in effect even if Public Act 98-651 does not become law until State fiscal year 2015.

(7.10a) For State fiscal years 2015 through 2018, 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 related to each State fiscal year:

Health Care Provider Relief Fund .... $50,000,000

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

(7.11) (Blank).

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

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

Health Care Provider Relief Fund ..... $2,870,000

Since the federal Centers for Medicare and Medicaid Services approval of the assessment authorized under subsection (b-5) of Section 5A-2, received from hospital providers under Section 5A-4 and the payment methodologies to hospitals required under Section 5A-12.4 was not received by the Department until State fiscal year 2014 and since the Department made retroactive payments during State fiscal year 2014 related to the referenced period of June 2012, the transfer authority granted in this paragraph (7.12) is extended through the date that is 10 State business days after June 16, 2014 (the effective date of Public Act 98-651).

(7.13) In addition to any other transfers authorized under this Section, for State fiscal years 2017 and 2018, for making transfers to the Healthcare Provider Relief Fund of moneys collected from the ACA Assessment Adjustment authorized under subsections (a) and (b-5) of Section 5A-2

and paid by hospital providers under Section 5A-4 into the Hospital Provider Fund under Section 5A-6 for each State fiscal year. Timing of transfers to the Healthcare Provider Relief Fund under this paragraph shall be at the discretion of the Department, but no less frequently than quarterly.

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

(9) For making payment to capitated managed care organizations as described in subsections (s) and (t) of Section 5A-12.2 of this Code.

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.

(3.5) As applicable, proceeds from surety bond

payments payable to the Department as referenced in subsection (s) of Section 5A-12.2 of this Code.

(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. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff. 7-20-15.)

(305 ILCS 5/5A-12.2)

(Section scheduled to be repealed on July 1, 2018)

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2008, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to

the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act.

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

(b) Across-the-board inpatient adjustment.

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

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

(3) In addition to rates paid for inpatient hospital services, the Department shall pay to each freestanding Illinois rehabilitation or psychiatric hospital an amount equal to $1,000 per Medicaid inpatient day multiplied by

the increase in the hospital's Medicaid inpatient utilization ratio (determined using the positive percentage change from the rate year 2005 Medicaid inpatient utilization ratio to the rate year 2007 Medicaid inpatient utilization ratio, as calculated by the Department for the disproportionate share determination).

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

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

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

(ii) For hospitals other than freestanding

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

(c) Outpatient adjustment.

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

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

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

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

provided during that period; and

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

(e) Capital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% (as calculated by the Department for the rate year 2007 disproportionate share determination) amounts as follows:

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

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

capital costs of all Illinois hospitals and the hospital's capital costs.

(f) Obstetrical care adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay $1,500 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois rural hospital that had a Medicaid obstetrical percentage (Medicaid obstetrical days divided by Medicaid inpatient days) greater than 15% for State fiscal year 2005.

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

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

(g) Trauma adjustment.

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

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

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

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

under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007.

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

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

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

(2) For hospitals located in a county whose eligibility growth factor is less than or equal to the mean, $225

multiplied by the eligibility growth factor for the county in which the hospital is located for each Medicaid inpatient day of care provided by the hospital during State fiscal year 2005.

For purposes of this subsection, "eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

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

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

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

(n) Definitions. Unless the context requires otherwise or unless provided otherwise in this Section, the terms used in

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

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

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

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

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

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

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

"Medicaid obstetrical day" means, for a given hospital, the sum of days of inpatient hospital days grouped by the Department to DRGs of 370 through 375 provided to recipients of medical assistance under Title XIX of the federal Social

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

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

(o) The Department may adjust payments made under this Section 5A-12.2 to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.

(p) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules that change the hospital access improvement payments specified in this Section, but only to the extent necessary to conform to any federally approved amendment to the Title XIX State plan. Any such rules shall be adopted by the Department as authorized by Section 5-50 of the Illinois Administrative Procedure Act.

Notwithstanding any other provision of law, any changes implemented as a result of this subsection (p) shall be given retroactive effect so that they shall be deemed to have taken effect as of the effective date of this Section.

(q) (Blank).

(r) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(s) On or after January 1, 2016 ~~July 1, 2014, but no later than October 1, 2014~~, and no less than annually thereafter, the Department shall ~~may~~ increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in this Section and in Section 5A-12.4 by a uniform percentage on a regional basis to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. The aggregate amount of all increased capitation payments to all MCOs for a fiscal year shall be the amount needed to avoid reduction in payments authorized under Section 5A-15. Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published by the Department each year. Each MCO shall only expend the increased capitation payments it receives under this Section to support the availability of hospital services and to ensure access to hospital services, with such

expenditures being made within 15 calendar days from when the MCO receives the increased capitation payment. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments made under this subsection shall be guaranteed by a surety bond obtained by the MCO in an amount established by the Department to approximate one month's liability of payments authorized under this subsection. The Department may advance the payments guaranteed by the surety bond. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection.

As used in this subsection, "MCO" means an entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

(t) On or after July 1, 2014, the Department may increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in Section 5A-12.5 to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. Effective January 1, 2016, the Department shall increase capitation payments to MCOs to include the payments authorized

under Section 5A-12.5 to preserve access to hospital services for recipients under the Illinois Medical Assistance Program by ensuring that the reimbursement provided for Affordable Care Act adults enrolled in a MCO is equivalent to the reimbursement provided for Affordable Care Act adults enrolled in a fee-for-service program. Payments to MCOs under this Section shall be consistent with actuarial certification and federal approval (which may be retrospectively determined) and shall be published by the Department each year. Each MCO shall only expend the increased capitation payments it receives under this Section to support the availability of hospital services and to ensure access to hospital services, with such expenditures being made within 15 calendar days from when the MCO receives the increased capitation payment. Payments made under this subsection may be guaranteed by a surety bond obtained by the MCO in an amount established by the Department to approximate one month's liability of payments authorized under this subsection. The Department may advance the payments to hospitals under this subsection, in the event the MCO fails to make such payments. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the

increased capitation payments under this subsection shall not be reduced as a consequence of payments made under this subsection.

As used in this subsection, "MCO" means an entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

(Source: P.A. 97-689, eff. 6-14-12; 98-651, eff. 6-16-14.)

(305 ILCS 5/5A-12.5)

Sec. 5A-12.5. Affordable Care Act adults; hospital access payments.

(a) The Department shall, subject to federal approval, mirror the Medical Assistance hospital reimbursement methodology for Affordable Care Act adults who are enrolled under a fee-for-service or capitated managed care program, including hospital access payments as defined in Section 5A-12.2 of this Article and hospital access improvement payments as defined in Section 5A-12.4 of this Article, in compliance with the equivalent rate provisions of the Affordable Care Act.

(b) If the fee-for-service payments authorized under this Section are deemed to be increases to payments for a prior period, the Department shall seek federal approval to issue such increases for the payments made through the period ending on June 30, 2018, even if such increases are paid out during an extended payment period beyond such date. Payment of such

increases beyond such date is subject to federal approval.

(c) As used in this Section, "Affordable Care Act" is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

(Source: P.A. 98-651, eff. 6-16-14.)

(305 ILCS 5/12-4.105 new)

Sec. 12-4.105. Human poison control center; payment program. Subject to funding availability resulting from transfers made from the Hospital Provider Fund to the Healthcare Provider Relief Fund as authorized under this Code, for State fiscal year 2017 and State fiscal year 2018, the Department of Healthcare and Family Services shall pay to the human poison control center designated under the Poison Control System Act an amount of not less than $3,000,000 for each of those State fiscal years that the human poison control center is in operation.

Section 20. The Lead Poisoning Prevention Act is amended by changing Section 15.1 as follows:

(410 ILCS 45/15.1)

Sec. 15.1. Funding. Beginning July 1, 2014 and ending June 30, 2015 ~~2018~~, a hospital satisfying the definition, as of July 1, 2014, of Section 5-5e.1 of the Illinois Public Aid Code and

located in DuPage County shall pay the sum of $2,000,000 annually in 4 equal quarterly installments to the human poison control center in existence as of July 1, 2014 and established under the authority of this Act.

(Source: P.A. 98-651, eff. 6-16-14.)

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