AN ACT concerning hospitals.

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

ARTICLE 5.

Section 5-1. Short title. This Article may be cited as the Public Health Program Beneficiary Employer Disclosure Law. References in this Article to "this Law" mean this Article.

Section 5-5. Definition. In this Law, "public health program" means either of the following:

(1) The medical assistance program under Article V of the Illinois Public Aid Code.

(2) The children's health insurance program under the Children's Health Insurance Program Act.

Section 5-10. Disclosure of employer required. An applicant for health care benefits under a public health program, or a person requesting uncompensated care in a hospital, may identify the employer or employers of the proposed beneficiary of the health care benefits. If the proposed public health program beneficiary is not employed, the applicant may identify the employer or employers of any adult who is responsible for providing all or some of the proposed beneficiary's support.

Section 5-15. Reporting of employer-provided health insurance information.

(a) Hospitals required to report information on the uncompensated care they provide pursuant to federal Medicare cost reporting shall determine, from information that may be provided by a person receiving uncompensated or charity care, whether that person is employed, and if the person is employed

the identity of the employer. The hospital shall annually submit to the Department a summary report of the employment status information obtained from persons receiving uncompensated or charity care, including available information regarding the cost of the care provided and the number of persons employed by each identified employer.

(b) Notwithstanding any other law to the contrary, the Department of Public Aid or its successor agency, in collaboration with the Department of Human Services and the Department of Financial and Professional Regulation, shall annually prepare a public health access program beneficiary employer report to be submitted to the General Assembly. For the purposes of this Section, a "public health access program beneficiary" means a person who receives medical assistance under Title XIX or XXI of the federal Social Security Act.

Subject to federal approval, the report shall provide the following information for each employer who has more than 100 employees and 25 or more public health access program beneficiaries:

(1) The name and address of the qualified employer.

(2) The number of public health access program beneficiaries.

(3) The number of persons requesting uncompensated or charity care from the hospitals required to report under this Section and the cost of that care.

(4) The number of public health access program beneficiaries who are spouses or dependents of employees of the employer.

(5) Information on whether the employer offers health insurance benefits to employees and their dependents.

(6) Information on whether the employer receives health insurance benefits through the company.

(7) Whether an employer offers health insurance benefits, and, if so, information on the level of premium subsidies for such health insurance.

(8) The cost to the State of Illinois of providing

public health access program benefits for the employer's employees and enrolled dependents.

(c) The report shall include a description of the methodology used in the collection of the data and an analysis regarding the effect of employment and health coverage on the assistance programs provided by the State. The Department shall include available data regarding: the numbers of employees and dependents of employees; the identity of employers by type of industry and by public, private, profit, or non-profit status; the employees' full-time or part-time status; and other variables that the Department determines essential.

(d) The report shall not include the names of any individual public health access program beneficiary and shall be subject to privacy standards both in the Health Insurance Portability and Accountability Act of 1996 and in Title XIX of the federal Social Security Act.

(e) The first report shall be submitted on or before October 1, 2006, and subsequent reports shall be submitted on or before that date each year thereafter.

Section 5-90. Repeal. This Law is repealed on January 1, 2009.

ARTICLE 10.

Section 10-1. Short title. This Article may be cited as the Illinois Adverse Health Care Events Reporting Law of 2005. References in this Article to "this Law" mean this Article.

Section 10-5. Purpose. The sole purpose of this Law is to establish an adverse health care event reporting system designed to facilitate quality improvement in the health care system through communication and collaboration between the Department and health care facilities. The reporting system established under this Law shall not be designed or, except as provided in this Law, used to punish errors or to investigate

or take disciplinary action against health care facilities, health care practitioners, or health care facility employees.

Section 10-10. Definitions. As used in this Law, the following terms have the following meanings:

"Adverse health care event" means any event described in subsections (b) through (g) of Section 10-15.

"Department" means the Illinois Department of Public Health.

"Health care facility" means a hospital maintained by the State or any department or agency thereof where such department or agency has authority under law to establish and enforce standards for the hospital under its management and control, a hospital maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation, a hospital licensed under the Hospital Licensing Act, a hospital organized under the University of Illinois Hospital Act, and an ambulatory surgical treatment center licensed under the Ambulatory Surgical Treatment Center Act.

Section 10-15. Health care facility requirements to report, analyze, and correct.

(a) Reports of adverse health care events required. Each health care facility shall report to the Department the occurrence of any of the adverse health care events described in subsections (b) through (g) no later than 30 days after discovery of the event. The report shall be filed in a format specified by the Department and shall identify the health care facility, but shall not include any information identifying or that tends to identify any of the health care professionals, employees, or patients involved.

(b) Surgical events. Events reportable under this subsection are:

(1) Surgery performed on a wrong body part that is not consistent with the documented informed consent for that

patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent.

(2) Surgery performed on the wrong patient.

(3) The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent.

(4) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(5) Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

(c) Product or device events. Events reportable under this subsection are:

(1) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product.

(2) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.

(3) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(d) Patient protection events. Events reportable under this subsection are:

(1) An infant discharged to the wrong person.

(2) Patient death or serious disability associated with patient disappearance for more than 4 hours, excluding events involving adults who have decision-making capacity.

(3) Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care facility due to patient actions after admission to the health care facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health care facility.

(e) Care management events. Events reportable under this subsection are:

(1) Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

(2) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

(3) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility, excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

(4) Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while

the patient is being cared for in a health care facility for a condition unrelated to hypoglycemia.

(f) Environmental events. Events reportable under this subsection are:

(1) Patient death or serious disability associated with an electric shock while being cared for in a health care facility, excluding events involving planned treatments such as electric countershock.

(2) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

(3) Patient death or serious disability associated with a burn incurred from any source while being cared for in a health care facility that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent.

(4) Patient death associated with a fall while being cared for in a health care facility.

(5) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility.

(g) Physical security events. Events reportable under this subsection are:

(1) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

(2) Abduction of a patient of any age.

(3) Sexual assault on a patient within or on the grounds of a health care facility.

(4) Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a health care facility.

(h) Definitions. As used in this Section 10-15:

"Death" means patient death related to an adverse event and not related solely to the natural course of the patient's illness or underlying condition. Events otherwise reportable under this Section 10-15 shall be reported even if the death might have otherwise occurred as the natural course of the patient's illness or underlying condition.

"Serious disability" means a physical or mental impairment, including loss of a body part, related to an adverse event and not related solely to the natural course of the patient's illness or underlying condition, that substantially limits one or more of the major life activities of an individual or a loss of bodily function, if the impairment or loss lasts more than 7 days prior to discharge or is still present at the time of discharge from an inpatient health care facility.

Section 10-20. Root cause analysis; corrective action plan. Following the occurrence of an adverse health care event, the health care facility must conduct a root cause analysis of the event. Following the analysis, the health care facility must (i) implement a corrective action plan to address the findings of the analysis or (ii) report to the Department any reasons for not taking corrective action. A copy of the findings of the root cause analysis and a copy of the corrective action plan must be filed with the Department within 90 days after the submission of the report to the Department under Section 10-15.

Section 10-25. Confidentiality. Other than the annual report required under paragraph (4) of Section 10-35 of this Law, adverse health care event reports, findings of root cause analyses, and corrective action plans filed by a health care facility under this Law and records created or obtained by the Department in reviewing or investigating these reports, findings, and plans shall not be available to the public and shall not be discoverable or admissible in any civil, criminal,

or administrative proceeding against a health care facility or health care professional. No report or Department disclosure under this Law may contain information identifying a patient, employee, or licensed professional. Notwithstanding any other provision of law, under no circumstances shall the Department disclose information obtained from a health care facility that is confidential under Part 21 of Article VIII of the Code of Civil Procedure. Nothing in this Law shall preclude or alter the reporting responsibilities of hospitals or ambulatory surgical treatment centers under existing federal or State law.

Section 10-30. Establishment of reporting system.

(a) The Department shall establish an adverse health event reporting system that will be fully operational by January 1, 2008 and designed to facilitate quality improvement in the health care system through communication and collaboration among the Department and health care facilities. The reporting system shall not be designed or used to punish errors or, except to enforce this Law, investigate or take disciplinary action against health care facilities, health care practitioners, or health care facility employees. The Department may not use the adverse health care event reports, findings of the root cause analyses, and corrective action plans filed under this Law for any purpose not stated in this Law, including, but not limited to, using such information for investigating possible violations of the reporting health care facility's licensing act or its regulations. The Department is not authorized to select from or between competing alternate health care treatments, services, or practices.

(b) The reporting system shall consist of:

(1) Mandatory reporting by health care facilities of adverse health care events.

(2) Mandatory completion of a root cause analysis and a corrective action plan by the health care facility and reporting of the findings of the analysis and the plan to the Department or reporting of reasons for not taking

corrective action.

(3) Analysis of reported information by the Department to determine patterns of systemic failure in the health care system and successful methods to correct these failures.

(4) Sanctions against health care facilities for failure to comply with reporting system requirements.

(5) Communication from the Department to health care facilities, to maximize the use of the reporting system to improve health care quality.

(c) In establishing the adverse health event reporting system, including the design of the reporting format and annual report, the Department must consult with and seek input from experts and organizations specializing in patient safety.

(d) The Department must design the reporting system so that a health care facility may file by electronic means the reports required under this Law. The Department shall encourage a health care facility to use the electronic filing option when that option is feasible for the health care facility.

(e) Nothing in this Section prohibits a health care facility from taking any remedial action in response to the occurrence of an adverse health care event.

Section 10-35. Analysis of reports; communication of findings. The Department shall do the following:

(1) Analyze adverse event reports, corrective action plans, and findings of the root cause analyses to determine patterns of systemic failure in the health care system and successful methods to correct these failures.

(2) Communicate to individual health care facilities the Department's conclusions, if any, regarding an adverse event reported by the health care facility.

(3) Communicate to relevant health care facilities any recommendations for corrective action resulting from the Department's analysis of submissions from facilities.

(4) Publish an annual report that does the following:

(i) Describes, by institution, adverse health care events reported.

(ii) Summarizes, in aggregate form, the corrective action plans and findings of root cause analyses submitted by health care facilities.

(iii) Describes adopted recommendations for quality improvement practices.

Section 10-40. Health Care Event Reporting Advisory Committee. The Department shall appoint a 9-person Health Care Event Reporting Advisory Committee with at least one member from each of the following statewide organizations: one representing hospitals; one representing ambulatory surgical treatment centers; and one representing physicians licensed to practice medicine in all its branches. The committee shall also include other individuals who have expertise and experience in system-based quality improvement and safety and shall include one public member. At least 3 of the 9 members shall be individuals who do not have a financial interest in, or a business relationship with, hospitals or ambulatory surgical treatment centers. The Health Care Event Reporting Advisory Committee shall review the Department's recommendations for potential quality improvement practices and modifications to the list of reportable adverse health care events consistent with national standards. In connection with its review of the Department's recommendations, the committee shall conduct a public hearing seeking input from health care facilities, health care professionals, and the public.

Section 10-45. Testing period.

(a) Prior to the testing period in subsection (b), the Department shall adopt rules for implementing this Law in consultation with the Health Care Event Reporting Advisory Committee and individuals who have experience and expertise in devising and implementing adverse health care event or other heath care quality reporting systems. The rules shall establish

the methodology and format for health care facilities reporting information under this Law to the Department and shall be finalized before the beginning of the testing period under subsection (b).

(b) The Department shall conduct a testing period of at least 6 months to test the reporting process to identify any problems or deficiencies with the planned reporting process.

(c) None of the information reported and analyzed during the testing period shall be used in any public report under this Law.

(d) The Department must substantially address the problems or deficiencies identified during the testing period before fully implementing the reporting system.

(e) After the testing period, and after any corrections, adjustments, or modifications are finalized, the Department must give at least 30 days written notice to health care facilities prior to full implementation of the reporting system and collection of adverse event data that will be used in public reports.

(f) Following the testing period, 4 calendar quarters of data must be collected prior to the Department's publishing the annual report of adverse events to the public under paragraph (4) of Section 10-35.

(g) The process described in subsections (a) through (e) must be completed by the Department no later than July 1, 2007.

(h) Notwithstanding any other provision of law, the Department may contract with an entity for receiving all adverse health care event reports, root cause analysis findings, and corrective action plans that must be reported to the Department under this Law and for the compilation of the information and the provision of quarterly and annual reports to the Department describing such information according to the rules adopted by the Department under this Law.

Section 10-50. Validity of public reports. None of the information the Department discloses to the public may be made

available in any form or fashion unless such information is shared with the health care facilities under review prior to public dissemination of such information. Those health care facilities shall have 30 days to make corrections and to add helpful explanatory comments about the information before the publication.

ARTICLE 90.

Section 90-5. The Ambulatory Surgical Treatment Center Act is amended by changing Section 10d as follows:

(210 ILCS 5/10d) (from Ch. 111 1/2, par. 157-8.10d)

Sec. 10d. Fines and penalties.

(a) When the Director determines that a facility has failed to comply with this Act or the Illinois Adverse Health Care Events Reporting Law of 2005 or any rule adopted under either of those Acts ~~hereunder~~, the Department may issue a notice of fine assessment which shall specify the violations for which the fine is assessed. The Department may assess a fine of up to $500 per violation per day commencing on the date the violation was identified and ending on the date the violation is corrected, or action is taken to suspend, revoke or deny renewal of the license, whichever comes first.

(b) In determining whether a fine is to be assessed or the amount of such fine, the Director shall consider the following factors:

(1) The gravity of the violation, including the probability that death or serious physical or mental harm to a patient will result or has resulted, the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or rules were violated;

(2) The reasonable diligence exercised by the licensee and efforts to correct violations;

(3) Any previous violations committed by the licensee;

and

(4) The financial benefit to the facility of committing or continuing the violation.

(Source: P.A. 86-1292.)

Section 90-10. The Hospital Licensing Act is amended by changing Section 7 as follows:

(210 ILCS 85/7) (from Ch. 111 1/2, par. 148)

Sec. 7. (a) The Director after notice and opportunity for hearing to the applicant or licensee may deny, suspend, or revoke a permit to establish a hospital or deny, suspend, or revoke a license to open, conduct, operate, and maintain a hospital in any case in which he finds that there has been a substantial failure to comply with the provisions of this Act, ~~or~~ the Hospital Report Card Act, or the Illinois Adverse Health Care Events Reporting Law of 2005 or the standards, rules, and regulations established by virtue of any ~~either~~ of those Acts.

(b) Such notice shall be effected by registered mail or by personal service setting forth the particular reasons for the proposed action and fixing a date, not less than 15 days from the date of such mailing or service, at which time the applicant or licensee shall be given an opportunity for a hearing. Such hearing shall be conducted by the Director or by an employee of the Department designated in writing by the Director as Hearing Officer to conduct the hearing. On the basis of any such hearing, or upon default of the applicant or licensee, the Director shall make a determination specifying his findings and conclusions. In case of a denial to an applicant of a permit to establish a hospital, such determination shall specify the subsection of Section 6 under which the permit was denied and shall contain findings of fact forming the basis of such denial. A copy of such determination shall be sent by registered mail or served personally upon the applicant or licensee. The decision denying, suspending, or revoking a permit or a license shall become final 35 days after

it is so mailed or served, unless the applicant or licensee, within such 35 day period, petitions for review pursuant to Section 13.

(c) The procedure governing hearings authorized by this Section shall be in accordance with rules promulgated by the Department and approved by the Hospital Licensing Board. A full and complete record shall be kept of all proceedings, including the notice of hearing, complaint, and all other documents in the nature of pleadings, written motions filed in the proceedings, and the report and orders of the Director and Hearing Officer. All testimony shall be reported but need not be transcribed unless the decision is appealed pursuant to Section 13. A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies.

(d) The Director or Hearing Officer shall upon his own motion, or on the written request of any party to the proceeding, issue subpoenas requiring the attendance and the giving of testimony by witnesses, and subpoenas duces tecum requiring the production of books, papers, records, or memoranda. All subpoenas and subpoenas duces tecum issued under the terms of this Act may be served by any person of full age. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the Circuit Court of this State, such fees to be paid when the witness is excused from further attendance. When the witness is subpoenaed at the instance of the Director, or Hearing Officer, such fees shall be paid in the same manner as other expenses of the Department, and when the witness is subpoenaed at the instance of any other party to any such proceeding the Department may require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness is summoned. In such case, the Department in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum issued as aforesaid shall be served in the same manner as a

subpoena issued out of a court.

(e) Any Circuit Court of this State upon the application of the Director, or upon the application of any other party to the proceeding, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before the Director or Hearing Officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

(f) The Director or Hearing Officer, or any party in an investigation or hearing before the Department, may cause the depositions of witnesses within the State to be taken in the manner prescribed by law for like depositions in civil actions in courts of this State, and to that end compel the attendance of witnesses and the production of books, papers, records, or memoranda.

(Source: P.A. 93-563, eff. 1-1-04.)

Section 90-15. The Illinois Public Aid Code is amended by changing Sections 5A-1, 5A-2, 5A-3, 5A-4, 5A-5, 5A-7, 5A-8, 5A-10, 5A-13, and 5A-14 and by adding Section 5A-12.1 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.

"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during

calendar year 2001. Occupied bed days shall be computed separately for each hospital operated or maintained by a hospital provider.

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

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

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

(Section scheduled to be repealed on July 1, 2005)

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

(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.

The Department of Public Aid 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 Public Aid, then the Department of Public Aid 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 Public Aid 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.

(b) Nothing in this Article ~~amendatory Act of the 93rd General Assembly~~ shall be construed to authorize any home rule unit or other unit of local government to license for revenue or to impose a tax or assessment upon hospital providers or the occupation of hospital provider, or a tax or assessment measured by the income or earnings of a hospital provider.

(c) As provided in Section 5A-14, this Section is repealed on July 1, 2008 ~~2005~~.

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04; 93-1066, eff. 1-15-05.)

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

Sec. 5A-3. Exemptions.

(a) (Blank).

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

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

(b-5) (Blank).

(b-10) For State fiscal years 2004 and 2005, a ~~A~~ hospital provider whose hospital does not charge for its services is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.

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

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

(b-25) For State fiscal years 2004 and 2005, a ~~A~~ hospital provider whose hospital (i) is not a psychiatric hospital, rehabilitation hospital, or children's hospital and (ii) has an average length of inpatient stay greater than 25 days is exempt from the assessment imposed by Section 5A-2, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital provider shall pay the assessment imposed by Section 5A-2.

(c) (Blank).

(Source: P.A. 93-659, eff. 2-3-04.)

(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 year 2006 and each subsequent State fiscal year 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. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after: (i) the hospital provider receives written notice from the Department of Public Aid that the payment methodologies to hospitals required under Section 5A-12 or Section 5A-12.1, 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 hospital has received the payments required under Section 5A-12 or Section 5A-12.1, whichever is applicable for that fiscal year. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12 or Section 5A-12.1, whichever is applicable for that fiscal year, and the waiver granted under 42 CFR 433.68, all quarterly 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 receipt of the payments required under Section 5A-12.1.

(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.

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04; 93-1066, eff. 1-15-05.)

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

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

(a) The Department of Public Aid 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 ~~within 14 days of~~ 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 or Section 5A-12.1, 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 or adjusted gross hospital 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 quarterly 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, <u>for State fiscal years 2004 and 2005,</u> 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. <u>Notwithstanding any other provision in this Article, for State fiscal years after 2005, 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</u>

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).

(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. ~~(Blank).~~

(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. ~~(Blank).~~

(h) (Blank).

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04.)

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

Sec. 5A-7. Administration; enforcement provisions.

(a) The Illinois Department shall establish and maintain a listing of all hospital providers appearing in the licensing records of the Illinois Department of Public Health, which shall show each provider's name and principal place of business and the name and address of each hospital operated, conducted, or maintained by the provider in this State. The Illinois Department shall administer and enforce this Article and collect the assessments and penalty assessments imposed under this Article using procedures employed in its administration of this Code generally. The Illinois Department, its Director, and every hospital provider subject to assessment under this Article ~~measured by occupied bed days~~ shall have the following

powers, duties, and rights:

(1) The Illinois Department may initiate either administrative or judicial proceedings, or both, to enforce provisions of this Article. Administrative enforcement proceedings initiated hereunder shall be governed by the Illinois Department's administrative rules. Judicial enforcement proceedings initiated hereunder shall be governed by the rules of procedure applicable in the courts of this State.

(2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than 3 years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Illinois Department and the hospital provider before the expiration of this limitation period.

(3) Any unpaid assessment under this Article shall become a lien upon the assets of the hospital upon which it was assessed. If any hospital provider, outside the usual course of its business, sells or transfers the major part of any one or more of (A) the real property and improvements, (B) the machinery and equipment, or (C) the furniture or fixtures, of any hospital that is subject to the provisions of this Article, the seller or transferor shall pay the Illinois Department the amount of any assessment, assessment penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by

the purchaser or transferee or until the purchaser or transferee receives from the Illinois Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Illinois Department showing that no assessment, penalty, or interest is due from the seller or transferor under this Article.

(4) Payments under this Article are not subject to the Illinois Prompt Payment Act. Credits or refunds shall not bear interest.

(b) In addition to any other remedy provided for and without sending a notice of assessment liability, the Illinois Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Illinois Department to the hospital provider.

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04.)

(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, VI, and XIV of this Code and under the Children's Health Insurance 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 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.

(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 years 2006, 2007 and 2008 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.

(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. 93-659, eff. 2-3-04.)

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

Sec. 5A-10. Applicability.

(a) The assessment 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) 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

(2) the 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 ~~2003~~, 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 ~~and except for changes in outpatient payment rates made to comply with the federal Health Insurance Portability and Accountability Act~~, so long as those changes do not reduce aggregate expenditures below the amount expended in State fiscal year 2005 ~~2003~~ for such services; or

(3) the payments to hospitals required under Section 5A-12 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 matching 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.

(Source: P.A. 93-659, eff. 2-3-04.)

(305 ILCS 5/5A-12.1 new)

Sec. 5A-12.1. Hospital access improvement payments.

(a) To preserve and improve access to hospital services, for hospital services rendered on or after August 1, 2005, the Department of Public Aid shall make payments to hospitals as set forth in this Section, except for hospitals described in subsection (b) of Section 5A-3. These payments shall be paid on a quarterly basis. For State fiscal year 2006, once the approval of the payment methodology required under this Section and any waiver required under 42 CFR 433.68 by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services is received, the Department shall pay the total amounts required for fiscal year 2006 under this Section within 100 days of the latest notification. In State fiscal years 2007 and 2008, the total amounts required under this

Section shall be paid in 4 equal installments on or before the seventh State business day of September, December, March, and May, except that if the date of notification of the approval of the payment methodologies required under this Section and any waiver required under 42 CFR 433.68 is on or after July 1, 2006, the sum of amounts required under this Section prior to the date of notification shall be paid within 100 days of the date of the last notification. 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, (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act, and (iii) the assessment is in effect.

(b) Medicaid eligibility payment. In addition to amounts paid for inpatient hospital services, the Department shall pay each Illinois hospital (except for hospitals described in Section 5A-3) for each inpatient Medicaid admission in State fiscal year 2003, $430 multiplied by the percentage by which the number of Medicaid recipients in the county in which the hospital is located increased from State fiscal year 1998 to State fiscal year 2003.

(c) Medicaid high volume adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois hospital (except for hospitals that qualify for Medicaid Percentage Adjustment payments under 89 Ill. Adm. Code 148.122 for the 12-month period beginning on October 1, 2004) that provided more than 10,000 Medicaid inpatient days of care (determined using the hospital's fiscal year 2002 Medicaid cost report on file with the Department on July 1, 2004) amounts as follows:

(i) for hospitals that provided more than 10,000 Medicaid inpatient days of care but less than or equal to 14,500 Medicaid inpatient days of care, $90 for each Medicaid inpatient day of care provided during that

period; and

(ii) for hospitals that provided more than 14,500 Medicaid inpatient days of care but less than or equal to 18,500 Medicaid inpatient days of care, $135 for each Medicaid inpatient day of care provided during that period; and

(iii) for hospitals that provided more than 18,500 Medicaid inpatient days of care but less than or equal to 20,000 Medicaid inpatient days of care, $225 for each Medicaid inpatient day of care provided during that period; and

(iv) for hospitals that provided more than 20,000 Medicaid inpatient days of care, $900 for each Medicaid inpatient day of care provided during that period.

Provided, however, that no hospital shall receive more than $19,000,000 per year in such payments under subparagraphs (i), (ii), (iii), and (iv).

(2) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital that as of October 1, 2004, qualified for Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122 and provided more than 21,000 Medicaid inpatient days of care (determined using the hospital's fiscal year 2002 Medicaid cost report on file with the Department on July 1, 2004) $35 for each Medicaid inpatient day of care provided during that period. Provided, however, that no hospital shall receive more than $1,200,000 per year in such payments.

(d) Intensive care adjustment. In addition to rates paid for inpatient services, the Department shall pay an adjustment payment to each Illinois general acute care hospital located in a large urban area that, based on the hospital's fiscal year 2002 Medicaid cost report, had a ratio of Medicaid intensive care unit days to total Medicaid days greater than 19%. If such ratio for the hospital is less than 30%, the hospital shall be paid an adjustment payment for each Medicaid inpatient day of

care provided equal to $1,000 multiplied by the hospital's ratio of Medicaid intensive care days to total Medicaid days. If such ratio for the hospital is equal to or greater than 30%, the hospital shall be paid an adjustment payment for each Medicaid inpatient day of care provided equal to $2,800 multiplied by the hospital's ratio of Medicaid intensive care days to total Medicaid days.

(e) Trauma center adjustments.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital that as of January 1, 2005, was designated as a Level I trauma center and is either located in a large urban area or is located in an other urban area and as of October 1, 2004 qualified for Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122, a payment equal to $800 multiplied by the hospital's Medicaid intensive care unit days (excluding Medicare crossover days). This payment shall be calculated based on data from the hospital's 2002 cost report on file with the Department on July 1, 2004. For hospitals located in large urban areas outside of a city with a population in excess of 1,000,000 people, the payment required under this subsection shall be multiplied by 4.5. For hospitals located in other urban areas, the payment required under this subsection shall be multiplied by 8.5.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that as of January 1, 2005, was designated as a Level II trauma center and is located in a county with a population in excess of 3,000,000 people. The payment shall equal $4,000 per day for the first 500 Medicaid inpatient days, $2,000 per day for the Medicaid inpatient days between 501 and 1,500, and $100 per day for any Medicaid inpatient day in excess of 1,500. This payment shall be calculated based on data from the hospital's 2002 cost report on file with the Department

on July 1, 2004.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that as of January 1, 2005, was designated as a Level II trauma center, is located in a large urban area outside of a county with a population in excess of 3,000,000 people, and as of January 1, 2005, was designated a Level III perinatal center or designated a Level II or II+ prenatal center that has a ratio of Medicaid intensive care unit days to total Medicaid days greater than 5%. The payment shall equal $4,000 per day for the first 500 Medicaid inpatient days, $2,000 per day for the Medicaid inpatient days between 501 and 1,500, and $100 per day for any Medicaid inpatient day in excess of 1,500. This payment shall be calculated based on data from the hospital's 2002 cost report on file with the Department on July 1, 2004.

(4) In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois children's hospital that as of January 1, 2005, was designated a Level I pediatric trauma center that had more than 30,000 Medicaid days in State fiscal year 2003 and to each Level I pediatric trauma center located outside of Illinois and that had more than 700 Illinois Medicaid cases in State fiscal year 2003. The amount of such payment shall equal $325 multiplied by the hospital's Medicaid intensive care unit days, and this payment shall be multiplied by 2.25 for hospitals located outside of Illinois. This payment shall be calculated based on data from the hospital's 2002 cost report on file with the Department on July 1, 2004.

(5) Notwithstanding any other provision of this subsection, a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3)(B), is not eligible for the payments described in paragraphs (1), (2), and (3) of this subsection.

(f) Psychiatric rate adjustment.

(1) In addition to rates paid for inpatient psychiatric services, the Department shall pay each Illinois psychiatric hospital and general acute care hospital with a distinct part psychiatric unit, for each Medicaid inpatient psychiatric day of care provided in State fiscal year 2003, an amount equal to $420 less the hospital's per diem rate for Medicaid inpatient psychiatric services as in effect on July 1, 2002. In no event, however, shall that amount be less than zero.

(2) For Illinois psychiatric hospitals and distinct part psychiatric units of Illinois general acute care hospitals whose inpatient per diem rate as in effect on July 1, 2002 is greater than $420, the Department shall pay, in addition to any other amounts authorized under this Code, $40 for each Medicaid inpatient psychiatric day of care provided in State fiscal year 2003.

(3) In addition to rates paid for inpatient psychiatric services, for Illinois psychiatric hospitals located in a county with a population in excess of 3,000,000 people that did not qualify for Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122 for the 12-month period beginning on October 1, 2004, the Illinois Department shall make an adjustment payment of $150 for each Medicaid inpatient psychiatric day of care provided by the hospital in State fiscal year 2003. In addition to rates paid for inpatient psychiatric services, for Illinois psychiatric hospitals located in a county with a population in excess of 3,000,000 people, but outside of a city with a population in excess of 1,000,000 people, that did qualify for Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122 for the 12-month period beginning on October 1, 2004, the Illinois Department shall make an adjustment payment of $20 for each Medicaid inpatient psychiatric day of care provided by the hospital in State fiscal year 2003.

(g) Rehabilitation adjustment.

(1) In addition to rates paid for inpatient rehabilitation services, the Department shall pay each Illinois general acute care hospital with a distinct part rehabilitation unit that had at least 40 beds as reported on the hospital's 2003 Medicaid cost report on file with the Department as of March 31, 2005, for each Medicaid inpatient day of care provided during State fiscal year 2003, an amount equal to $230.

(2) In addition to rates paid for inpatient rehabilitation services, for Illinois rehabilitation hospitals that did not qualify for Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122 for the 12-month period beginning on October 1, 2004, the Illinois Department shall make an adjustment payment of $200 for each Medicaid inpatient day of care provided during State fiscal year 2003.

(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 2005, a supplemental tertiary care adjustment payment equal to 2.5 multiplied by the tertiary care adjustment payment required under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2005.

(i) Crossover percentage adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois general acute care hospital, excluding any hospital defined as a cancer center hospital in rules by the Department, located in an urban area that provided over 500 days of inpatient care to Medicaid recipients, that had a ratio of crossover days to total Medicaid days, utilizing information used for the Medicaid percentage adjustment determination described in 84 Ill. Adm. Code 148.122, effective October 1, 2004, of greater than 40%, and that does not qualify for Medicaid percentage adjustment payments under 89 Ill. Adm. Code

148.122, on October 1, 2004, an amount as follows:

(1) for hospitals located in an other urban area, $140 per Medicaid inpatient day (including crossover days);

(2) for hospitals located in a large urban area whose ratio of crossover days to total Medicaid days is less than 55%, $350 per Medicaid inpatient day (including crossover days);

(3) for hospitals located in a large urban area whose ratio of crossover days to total Medicaid days is equal to or greater than 55%, $1,400 per Medicaid inpatient day (including crossover days).

The term "Medicaid days" in paragraphs (1), (2), and (3) of this subsection (i) means the Medicaid days utilized for the Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122 for the October 1, 2004 determination.

(j) Long term acute care hospital adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois long term acute care hospital that, as of October 1, 2004, qualified for a Medicaid percentage adjustment under 89 Ill. Adm. Code 148.122, $125 for each Medicaid inpatient day of care provided in State fiscal year 2003. In addition to rates paid for inpatient services, the Department shall pay each long term acute care hospital that, as of October 1, 2004, did not qualify for a Medicaid percentage adjustment under 89 Ill. Adm. Code 148.122, $1,250 for each Medicaid inpatient day of care provided in State fiscal year 2003. For purposes of this subsection, "long term acute care hospital" means a hospital that (i) is not a psychiatric hospital, rehabilitation hospital, or children's hospital and (ii) has an average length of inpatient stay greater than 25 days.

(k) Obstetrical care adjustments.

(1) In addition to rates paid for inpatient services, the Department shall pay each Illinois hospital an amount equal to $550 multiplied by each Medicaid obstetrical day of care provided by the hospital in State fiscal year 2003.

(2) In addition to rates paid for inpatient services,

the Department shall pay each Illinois hospital that qualified as a Medicaid disproportionate share hospital under 89 Ill. Adm. Code 148.120 as of October 1, 2004, and that had a Medicaid obstetrical percentage greater than 10% and a Medicaid emergency care percentage greater than 40%, an amount equal to $650 multiplied by each Medicaid obstetrical day of care provided by the hospital in State fiscal year 2003.

(3) In addition to rates paid for inpatient services, the Department shall pay each Illinois hospital that is located in the St. Louis metropolitan statistical area and that provided more than 500 Medicaid obstetrical days of care in State fiscal year 2003, an amount equal to $1,800 multiplied by each Medicaid obstetrical day of care provided by the hospital in State fiscal year 2003.

(4) In addition to rates paid for inpatient services, the Department shall pay $600 for each Medicaid obstetrical day of care provided in State fiscal year 2003 by each Illinois hospital that (i) is located in a large urban area, (ii) is located in a county whose number of Medicaid recipients increased from State fiscal year 1998 to State fiscal year 2003 by more than 60%, and (iii) that had a Medicaid obstetrical percentage used for the October 1, 2004, Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122 greater than 25%.

(5) In addition to rates paid for inpatient services, the Department shall pay $400 for each Medicaid obstetrical day of care provided in State fiscal year 2003 by each Illinois rural hospital that (i) was designated a Level II perinatal center as of January 1, 2005, (ii) had a Medicaid inpatient utilization rate greater than 34% in State fiscal year 2002, and (iii) had a Medicaid obstetrical percentage used for the October 1, 2004, Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122 greater than 15%.

(l) Outpatient access payments. In addition to the rates

paid for outpatient hospital services, the Department shall pay each Illinois hospital (except for hospitals described in Section 5A-3), an amount equal to 2.38 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during State fiscal year 2003 multiplied by the percentage by which the number of Medicaid recipients in the county in which the hospital is located increased from State fiscal year 1998 to State fiscal year 2003.

(m) Outpatient utilization payment.

(1) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois rural hospital, an amount equal to 1.7 multiplied by the hospital's outpatient ambulatory procedure listing payments for services provided during State fiscal year 2003.

(2) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois hospital located in an urban area, an amount equal to 0.45 multiplied by the hospital's outpatient ambulatory procedure listing payments received for services provided during State fiscal year 2003.

(n) Outpatient complexity of care adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois hospital located in an urban area an amount equal to 2.55 multiplied by the hospital's emergency care percentage multiplied by the hospital's outpatient ambulatory procedure listing payments received for services provided during State fiscal year 2003. For children's hospitals with an inpatient utilization rate used for the October 1, 2004, Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122 greater than 90%, this adjustment shall be multiplied by 2. For cancer center hospitals, this adjustment shall be multiplied by 3.

(o) Rehabilitation hospital adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding rehabilitation hospital

that does not qualify for a Medicaid percentage adjustment under 89 Ill. Adm. Code 148.122 as of October 1, 2004, an amount equal to 3 multiplied by the hospital's outpatient ambulatory procedure listing payments for Group 6A services provided during State fiscal year 2003.

(p) Perinatal outpatient adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay an adjustment payment to each large urban general acute care hospital that is designated as a perinatal center as of January 1, 2005, has a Medicaid obstetrical percentage of at least 10% used for the October 1, 2004, Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122, has a Medicaid intensive care unit percentage of at least 3%, and has a ratio of ambulatory procedure listing Level 3 services to total ambulatory procedure listing services of at least 50%. The amount of the adjustment payment under this subsection shall be $550 multiplied by the hospital's outpatient ambulatory procedure listing Level 3A services provided in State fiscal year 2003. If the hospital, as of January 1, 2005, was designated a Level III or II+ perinatal center, the adjustment payments required by this subsection shall be multiplied by 4.

(q) Supplemental psychiatric adjustment payments. In addition to rates paid for inpatient services, the Department shall pay to each Illinois hospital that does not qualify for Medicaid percentage adjustments described in 89 Ill. Adm. Code 148.122 but is eligible for psychiatric adjustment payments under 89 Ill. Adm. Code 148.105 for State fiscal year 2005, a supplemental psychiatric adjustment payment equal to 0.7 multiplied by the psychiatric adjustment payment required under 89 Ill. Adm. Code 148.105, as in effect for State fiscal year 2005.

(r) Outpatient community access adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay an adjustment payment to each general acute care hospital that is designated as a perinatal center as of January

1, 2005, that had a Medicaid obstetrical percentage used for the October 1, 2004, Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122 of at least 12.5%, that had a ratio of crossover days to total Medicaid days utilizing information used for the Medicaid percentage adjustment described in 89 Ill. Adm. Code 148.122 determination effective October 1, 2004, of greater than or equal to 25%, and that qualified for the Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122 on October 1, 2004, an amount equal to $100 multiplied by the hospital's outpatient ambulatory procedure listing services provided during State fiscal year 2003.

(s) 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 May 1, 2005. Other terms shall be defined by the Illinois Department by rule.

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

"Emergency care percentage" means a fraction, the numerator of which is the total Group 3 ambulatory procedure listing services provided by the hospital in State fiscal year 2003, and the denominator of which is the total ambulatory procedure listing services provided by the hospital in State fiscal year 2003.

"Large urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget in OMB Bulletin 04-03, dated February 18, 2004, with a population in excess of 1,000,000.

"Medicaid intensive care unit days" means the number of hospital inpatient days during which Medicaid recipients received intensive care services from the hospital, as determined from the hospital's 2002 Medicaid cost report that was on file with the Department as of July 1, 2004.

"Other urban area" means an area located within a metropolitan statistical area, as defined by the U.S. Office of Management and Budget in OMB Bulletin 04-03, dated February 18, 2004, with a city with a population in excess of 50,000 or a total population in excess of 100,000.

(t) For purposes of this Section, a hospital that enrolled to provide Medicaid services during State fiscal year 2003 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this Section.

(u) 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 was liable for payment, except where explicitly stated otherwise in this Section.

(v) As provided in Section 5A-14, this Section is repealed on July 1, 2008.

(305 ILCS 5/5A-13)

Sec. 5A-13. Emergency rulemaking. The Department of Public Aid may adopt rules necessary to implement this amendatory Act of the 94th ~~93rd~~ 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 ~~93rd~~ General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(Source: P.A. 93-659, eff. 2-3-04.)

(305 ILCS 5/5A-14)

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

(a) Section 5A-2 is repealed on July 1, 2008 ~~2005~~.

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

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

(Source: P.A. 93-659, eff. 2-3-04.)

Section 90-97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 90-99. Effective date. This Act takes effect upon becoming law.