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 5-50 as follows:

(5 ILCS 100/5-50) (from Ch. 127, par. 1005-50)

Sec. 5-50. Peremptory rulemaking. "Peremptory rulemaking" means any rulemaking that is required as a result of federal law, federal rules and regulations, an order of a court, or a collective bargaining agreement pursuant to subsection (d) of Section 1-5, under conditions that preclude compliance with the general rulemaking requirements imposed by Section 5-40 and that preclude the exercise of discretion by the agency as to the content of the rule it is required to adopt. Peremptory rulemaking shall not be used to implement consent orders or other court orders adopting settlements negotiated by the agency. If any agency finds that peremptory rulemaking is necessary and states in writing its reasons for that finding, the agency may adopt peremptory rulemaking upon filing a notice of rulemaking with the Secretary of State under Section 5-70. The notice shall be published in the Illinois Register. A rule adopted under the peremptory rulemaking provisions of this Section becomes effective immediately upon filing with the

Secretary of State and in the agency's principal office, or at a date required or authorized by the relevant federal law, federal rules and regulations, or court order, as stated in the notice of rulemaking. Notice of rulemaking under this Section shall be published in the Illinois Register, shall specifically refer to the appropriate State or federal court order or federal law, rules, and regulations, and shall be in a form as the Secretary of State may reasonably prescribe by rule. The agency shall file the notice of peremptory rulemaking within 30 days after a change in rules is required.

The Department of Healthcare and Family Services may adopt peremptory rulemaking under the terms and conditions of this Section to implement final payments included in a State Medicaid Plan Amendment approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and authorized under Section 5A-12.2 of the Illinois Public Aid Code, and to adjust hospital provider assessments as Medicaid Provider-Specific Taxes permitted by Title XIX of the federal Social Security Act and authorized under Section 5A-2 of the Illinois Public Aid Code.

(Source: P.A. 87-823; 88-667, eff. 9-16-94.)

(30 ILCS 105/5.620 rep.)

(30 ILCS 105/6z-56 rep.)

Section 10. The State Finance Act is amended by repealing Sections 5.620 and 6z-56.

Section 15. The Illinois Public Aid Code is amended by changing Sections 5A-1, 5A-2, 5A-3, 5A-4, 5A-5, 5A-8, 5A-10, 5A-14, 15-2, 15-3, 15-5, and 15-8 and by adding Sections 5A-12.2, 15-10, and 15-11 as follows:

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

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

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

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

"Fund" means the Hospital Provider Fund.

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

"Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this paragraph, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

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

"Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds, excluding days attributable to the routine services provided to persons receiving skilled or intermediate long term care services ~~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; 94-242, eff. 7-18-05.)

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

(Section scheduled to be repealed on July 1, 2008)

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.

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

Subject to Sections 5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007, and 2008, in an amount equal to 2.5835% of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835% of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's

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

Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2013, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days.

For State fiscal years 2009 through 2013, 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). ~~Nothing in this Article 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) (Blank). ~~As provided in Section 5A-14, this Section is repealed on July 1, 2008.~~

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

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a

timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04; 93-1066, eff. 1-15-05; 94-242, eff. 7-18-05; 94-838, eff. 6-6-06.)

(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 through 2013 ~~and 2005~~, a hospital provider, described in Section 1903(w)(3)(F) of the Social Security Act, 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 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 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 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; 94-242, eff. 7-18-05.)

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

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

(a) The annual assessment imposed by Section 5A-2 for State fiscal year 2004 shall be due and payable on June 18 of the year. The assessment imposed by Section 5A-2 for State fiscal year 2005 shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on July 19, October 19, January 18, and April 19 of the year. The assessment imposed by Section 5A-2 for State fiscal years ~~year~~ 2006 through 2008 ~~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. The assessment imposed by Section 5A-2 for State fiscal year 2009 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the fourteenth State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after:

(i) the Department notifies the hospital provider, in writing, ~~receives written notice from the Department of Healthcare and Family Services (formerly Department of Public Aid)~~ that the payment methodologies to hospitals required under Section 5A-12, ~~or~~ Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waiver under 42 CFR 433.68 for the assessment imposed by Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued ~~the hospital has received~~ the payments required under Section 5A-12, ~~or~~ Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12, ~~or~~ Section 5A-12.1, or Section 5A-12.2, whichever is applicable for that fiscal year, and the waiver granted under 42 CFR 433.68, all ~~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 issuance by the Comptroller ~~receipt~~ of the payments required under Section 5A-12.1 or Section 5A-12.2, whichever is applicable for that fiscal year.

(b) The Illinois Department is authorized to establish delayed payment schedules for hospital providers that are

unable to make installment payments when due under this Section due to financial difficulties, as determined by the Illinois Department.

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

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

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

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

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

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

(1) The name of the hospital provider.

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

(3) The occupied bed days, occupied bed days less Medicare days, or adjusted gross hospital revenue 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, for State fiscal years 2004 and 2005, in the case of a hospital provider that did not conduct, operate, or maintain a hospital throughout calendar year 2001, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for State fiscal years 2006 through 2008 ~~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 fiscal year as determined by the Illinois Department (which may be based on annualization of the provider's actual revenues for a portion of the year, or revenues of a comparable hospital for the year, including revenues realized by a prior provider of the same hospital during the year). Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2013, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department.

(f) Every hospital provider subject to assessment under

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

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

(h) (Blank).

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

(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, and under the Covering ALL KIDS Health Insurance 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 year 2006 for making transfers to the Health and Human Services Medicaid Trust Fund of up to $130,000,000 per year of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

(7.5) For State fiscal year 2007 for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health and Human Services

Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

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

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

(7.8) For State fiscal year 2008, for making transfers of the moneys received from hospital providers under

Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health and Human Services

Medicaid Trust Fund $40,000,000

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

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

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

(7.9) For State fiscal years 2009 through 2013, for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health and Human Services

Medicaid Trust Fund $20,000,000

Long Term Care Provider Fund $30,000,000

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

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

(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. 94-242, eff. 7-18-05; 94-839, eff. 6-6-06; 95-707, eff. 1-11-08.)

(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 ~~the~~ sum of the appropriations for State fiscal years 2004 and 2005 from the General Revenue Fund for hospital payments under the medical assistance program is less than $4,500,000,000 or the appropriation for each of State fiscal years 2006, 2007 and 2008 from the General Revenue Fund for hospital payments under the medical assistance program is less than $2,500,000,000 increased annually to reflect any increase in the number of recipients, or the annual appropriation for State fiscal years 2009 through 2013, from the General Revenue Fund for hospital payments under the medical assistance program, is less than the amount appropriated for State fiscal year 2009, adjusted annually to reflect any change in the number of recipients; or

(2) For State fiscal years prior to State fiscal year 2009, the Department of Healthcare and Family Services (formerly Department of Public Aid) makes changes in its rules that reduce the hospital inpatient or outpatient payment rates, including adjustment payment rates, in effect on October 1, 2004, except for hospitals described in subsection (b) of Section 5A-3 and except for changes in the methodology for calculating outlier payments to

hospitals for exceptionally costly stays, so long as those changes do not reduce aggregate expenditures below the amount expended in State fiscal year 2005 for such services; or

(2.1) For State fiscal years 2009 through 2013, the Department of Healthcare and Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008 except for:

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

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

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

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

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund

derived from assessments imposed prior thereto shall be disbursed in accordance with Section 5A-8 to the extent federal financial participation ~~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. 94-242, eff. 7-18-05; 95-331, eff. 8-21-07.)

(305 ILCS 5/5A-12.2 new)

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.

(b) Across-the-board inpatient adjustment.

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

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

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

(4) In addition to rates paid for inpatient hospital

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

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

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

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

(c) Outpatient adjustment.

(1) In addition to the rates paid for outpatient

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

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

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

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

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

(e) Capital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital

that has a Medicaid inpatient utilization rate of at least 10% (as calculated by the Department for the rate year 2007 disproportionate share determination) amounts as follows:

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

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

(f) Obstetrical care adjustment.

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

obstetrical percentage (Medicaid obstetrical days divided by Medicaid inpatient days) greater than 15% for State fiscal year 2005.

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

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

(g) Trauma adjustment.

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

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

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

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

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

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

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

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

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

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

to State fiscal year 2005.

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

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

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

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

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

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

"Capital costs" means, for a given hospital, the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies (DRI) hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department may obtain the data necessary to compute the hospital's capital costs from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

"Case mix index" means, for a given hospital, the sum of the DRG relative weighting factors in effect on January 1,

2005, for all general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, divided by the total number of general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

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

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

"Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory

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

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

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

(q) For State fiscal years 2012 and 2013, the Department may make recommendations to the General Assembly regarding the use of more recent data for purposes of calculating the

assessment authorized under Section 5A-2 and the payments authorized under this Section 5A-12.2.

(305 ILCS 5/5A-14)

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

(a) Section 5A-2 is repealed on July 1, 2013 ~~2008~~.

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

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

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

(Source: P.A. 93-659, eff. 2-3-04; 94-242, eff. 7-18-05.)

(305 ILCS 5/15-2) (from Ch. 23, par. 15-2)

Sec. 15-2. County Provider Trust Fund.

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

(b) The Fund is created solely for the purposes of receiving, investing, and distributing monies in accordance with this Article XV. The Fund shall consist of:

(1) All monies collected or received by the Illinois Department under Section 15-3 of this Code;

(2) All federal financial participation monies received by the Illinois Department pursuant to Title XIX of the Social Security Act, 42 U.S.C. 1396b ~~1396(b)~~,

attributable to eligible expenditures made by the Illinois Department pursuant to Section 15-5 of this Code;

(3) All federal moneys received by the Illinois Department pursuant to Title XXI of the Social Security Act attributable to eligible expenditures made by the Illinois Department pursuant to Section 15-5 of this Code; and

(4) All other monies received by the Fund from any source, including interest thereon.

(c) Disbursements from the Fund shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department and shall be made only:

(1) For hospital inpatient care, hospital outpatient care, care provided by other outpatient facilities operated by a county, and disproportionate share hospital <u>adjustment</u> payments made under Title XIX of the Social Security Act and Article V of this Code as required by Section 15-5 of this Code;

(1.5) For services provided by county providers pursuant to Section 5-11 of this Code;

(2) For the reimbursement of administrative expenses incurred by county providers on behalf of the Illinois Department as permitted by Section 15-4 of this Code;

(3) For the reimbursement of monies received by the Fund through error or mistake;

(4) For the payment of administrative expenses

necessarily incurred by the Illinois Department or its agent in performing the activities required by this Article XV;

(5) For the payment of any amounts that are reimbursable to the federal government, attributable solely to the Fund, and required to be paid by State warrant; and

(6) For hospital inpatient care, hospital outpatient care, care provided by other outpatient facilities operated by a county, and disproportionate share hospital adjustment payments made under Title XXI of the Social Security Act, pursuant to Section 15-5 of this Code.

(Source: P.A. 91-24, eff. 7-1-99; 92-370, eff. 8-15-01.)

(305 ILCS 5/15-3) (from Ch. 23, par. 15-3)

Sec. 15-3. Intergovernmental Transfers.

(a) Each qualifying county shall make an annual intergovernmental transfer to the Illinois Department in an amount equal to ~~71.7% of~~ the difference between the total payments made by the Illinois Department ~~to such county provider for hospital services under Titles XIX and XXI of the Social Security Act or~~ pursuant to subsection (a) of Section 15-5 ~~5-11~~ of this Code and the total federal financial participation monies received by the fund in each fiscal year ending June 30 ~~(or fraction thereof during the fiscal year ending June 30, 1993) and $108,800,000 (or fraction thereof),~~

~~except that the annual intergovernmental transfer shall not exceed the total payments made by the Illinois Department to such county provider for hospital services under this Code, less the sum of (i) 50% of payments reimbursable under the Social Security Act at a rate of 50% and (ii) 65% of payments reimbursable under the Social Security Act at a rate of 65%, in each fiscal year ending June 30 (or fraction thereof)~~.

(b) The payment schedule for the intergovernmental transfer made hereunder shall be established by intergovernmental agreement between the Illinois Department and the applicable county, which agreement shall at a minimum provide:

(1) For periodic payments no less frequently than monthly to the county provider for inpatient and outpatient approved or adjudicated claims and for disproportionate share adjustment payments as may be specified in the Illinois Title XIX State plan. ~~under Section 5-5.02 of this Code (in the initial year, for services after July 1, 1991, or such other date as an approved State Medical Assistance Plan shall provide).~~

(2) (Blank.) ~~For periodic payments no less frequently than monthly to the county provider for supplemental disproportionate share payments hereunder based on a federally approved State Medical Assistance Plan.~~

(3) For calculation of the intergovernmental transfer payment to be made by the county equal to ~~71.7% of~~ the

difference between the amount of the periodic payments to county providers ~~payment~~ and any amount of federal financial participation due the Illinois Department under Titles XIX and XXI of the Social Security Act as a result of such payments to county providers. ~~the base amount; provided, however, that if the periodic payment for any period is less than the base amount for such period, the base amount for the succeeding period (and any successive period if necessary) shall be increased by the amount of such shortfall.~~

(4) For an intergovernmental transfer methodology which obligates the Illinois Department to notify the county ~~and county provider~~ in writing of each impending periodic payment and the intergovernmental transfer payment attributable thereto and which obligates the Comptroller to release the periodic payment to the county provider within one working day of receipt of the intergovernmental transfer payment from the county.

(Source: P.A. 91-24, eff. 7-1-99; 92-370, eff. 8-15-01.)

(305 ILCS 5/15-5) (from Ch. 23, par. 15-5)

Sec. 15-5. Disbursements from the Fund.

(a) The monies in the Fund shall be disbursed only as provided in Section 15-2 of this Code and as follows:

(1) To the extent that such costs are reimbursable under federal law, to pay the county hospitals' inpatient

reimbursement rates ~~rate~~ based on actual costs incurred, trended forward annually by an inflation index. ~~and supplemented by teaching, capital, and other direct and indirect costs, according to a State plan approved by the federal government. Effective October 1, 1992, the inpatient reimbursement rate (including any disproportionate or supplemental disproportionate share payments) for hospital services provided by county operated facilities within the County shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992 and each July 1 thereafter through July 1, 2002 by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost report. Effective July 1, 2003, the rate for hospital inpatient services provided by county hospitals shall be the rate in effect on January 1, 2003, except that this minimum may be adjusted by the Illinois Department to ensure compliance with aggregate and hospital specific federal payment limitations.~~

(2) To the extent that such costs are reimbursable under federal law, to pay county hospitals and county operated outpatient facilities for outpatient services based on a federally approved methodology to cover the maximum allowable costs. ~~per patient visit. Effective October 1, 1992, the outpatient reimbursement rate for~~

~~outpatient services provided by county hospitals and county operated outpatient facilities shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992 and each July 1 thereafter through July 1, 2002 by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost report. Effective July 1, 2003, the Illinois Department shall by rule establish rates for outpatient services provided by county hospitals and other county-operated facilities within the County that are in compliance with aggregate and hospital-specific federal payment limitations.~~

(3) To pay the county hospitals ~~hospitals'~~ disproportionate share hospital adjustment payments as may be specified in the Illinois Title XIX State plan. ~~as established by the Illinois Department under Section 5-5.02 of this Code. Effective October 1, 1992, the disproportionate share payments for hospital services provided by county operated facilities within the County shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992 and each July 1 thereafter through July 1, 2002 by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost report. Effective July 1, 2003,~~

~~the Illinois Department may by rule establish rates for disproportionate share payments to county hospitals that are in compliance with aggregate and hospital-specific federal payment limitations.~~

(3.5) To pay county providers for services provided pursuant to Section 5-11 of this Code.

(4) To reimburse the county providers for expenses contractually assumed pursuant to Section 15-4 of this Code.

(5) To pay the Illinois Department its necessary administrative expenses relative to the Fund and other amounts agreed to, if any, by the county providers in the agreement provided for in subsection (c).

(6) To pay the county providers any other amount due according to a federally approved State plan, including but not limited to payments made under the provisions of Section 701(d)(3)(B) of the federal Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Intergovernmental transfers supporting payments under this paragraph (6) shall not be subject to the computation described in subsection (a) of Section 15-3 of this Code, but shall be computed as the difference between the total of such payments made by the Illinois Department to county providers less any amount of federal financial participation due the Illinois Department under Titles XIX and XXI of the Social Security Act as a result of such

payments to county providers.

(b) The Illinois Department shall promptly seek all appropriate amendments to the Illinois Title XIX State Plan to maximize reimbursement, including disproportionate share hospital adjustment payments, to the county providers ~~effect the foregoing payment methodology~~.

(c) (Blank). ~~The Illinois Department shall implement the changes made by Article 3 of this amendatory Act of 1992 beginning October 1, 1992. All terms and conditions of the disbursement of monies from the Fund not set forth expressly in this Article shall be set forth in the agreement executed under the Intergovernmental Cooperation Act so long as those terms and conditions are not inconsistent with this Article or applicable federal law. The Illinois Department shall report in writing to the Hospital Service Procurement Advisory Board and the Health Care Cost Containment Council by October 15, 1992, the terms and conditions of all such initial agreements and, where no such initial agreement has yet been executed with a qualifying county, the Illinois Department's reasons that each such initial agreement has not been executed. Copies and reports of amended agreements following the initial agreements shall likewise be filed by the Illinois Department with the Hospital Service Procurement Advisory Board and the Health Care Cost Containment Council within 30 days following their execution. The foregoing filing obligations of the Illinois Department are informational only, to allow the Board and~~

~~Council, respectively, to better perform their public roles, except that the Board or Council may, at its discretion, advise the Illinois Department in the case of the failure of the Illinois Department to reach agreement with any qualifying county by the required date.~~

(d) The payments provided for herein are intended to cover services rendered on and after July 1, 1991, and any agreement executed between a qualifying county and the Illinois Department pursuant to this Section may relate back to that date, provided the Illinois Department obtains federal approval. Any changes in payment rates resulting from the provisions of Article 3 of this amendatory Act of 1992 are intended to apply to services rendered on or after October 1, 1992, and any agreement executed between a qualifying county and the Illinois Department pursuant to this Section may be effective as of that date.

(e) If one or more hospitals file suit in any court challenging any part of this Article XV, payments to hospitals from the Fund under this Article XV shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement and may be disbursed under any order of the court.

(f) All payments under this Section are contingent upon federal approval of changes to the Title XIX State plan, if that approval is required.

(Source: P.A. 92-370, eff. 8-15-01; 93-20, eff. 6-20-03.)

(305 ILCS 5/15-8) (from Ch. 23, par. 15-8)

Sec. 15-8. Federal disallowances. In the event of any federal deferral or disallowance of any federal matching funds obtained through this Article which have been disbursed by the Illinois Department under this Article based upon challenges to reimbursement methodologies, ~~methodology or disproportionate share methodology,~~ the full faith and credit of the county is pledged for repayment by the county of those amounts deferred or disallowed to the Illinois Department.

(Source: P.A. 87-13.)

(305 ILCS 5/15-10 new)

Sec. 15-10. Disproportionate share hospital adjustment payments.

(a) The provisions of this Section become operative if:

(1) The federal government approves State Plan Amendment transmittal number 08-06 or a State Plan Amendment that permits disproportionate share hospital adjustment payments to be made to county hospitals.

(2) Proposed federal regulations, or other regulations or limitations driven by the federal government, negatively impact the net revenues realized by county providers from the Fund during a State fiscal year by more than 15%, as measured by the aggregate average net monthly

payment received by the county providers from the Fund from July 2007 through May 2008.

(3) The county providers have in good faith submitted timely, complete, and accurate cost reports and supplemental documents as required by the Illinois Department.

(4) the county providers maintain and bill for service volumes to individuals eligible for medical assistance under this Code that are no lower than 85% of the volumes provided by and billed to the Illinois Department by the county providers associated with payments received by the county providers from July 2007 through May 2008. Given the substantial financial burdens of the county associated with uncompensated care, the Illinois Department shall make good faith efforts to work with the county to maintain Medicaid volumes to the extent that the county has the adequate capacity to meet the obligations of patient volumes.

The Illinois Department and the county shall include in an intergovernmental agreement the process by which these conditions are assessed. The parties may, if necessary, contract with a large, nationally recognized public accounting firm to carry out this function.

(b) If the conditions of subsection (a) are met, and subject to appropriation or other available funding for such purpose, the Illinois Department shall make a payment or

otherwise make funds available to the county hospitals, during the lapse period, that provides for total payments to be at least at a level that is equivalent to the total fee-for-service payments received by the county providers that are enrolled with the Illinois Department to provide services during the fiscal year of the payment from the Fund from July 2007 through May 2008 multiplied by twelve-elevenths.

(c) In addition, notwithstanding any provision in subsection (a), the Illinois Department shall maximize disproportionate share hospital adjustment payments to the county hospitals that, at a minimum, are 42% of the State's federal fiscal year 2007 disproportionate share allocation.

(d) For the purposes of this Section, "net revenues" means the difference between the total fee-for-service payments made by the Illinois Department to county providers less the intergovernmental transfer made by the county in support of those payments.

(e) If (i) the disproportionate share hospital adjustment State Plan Amendment referenced in subdivision (a)(1) is not approved, or (ii) any reconciliation of payments to costs incurred would require repayment to the federal government of at least $2,500,000, or (iii) there is no funding available for the Illinois Department's obligations under subsection (b), the Illinois Department, the county, and the leadership of the General Assembly shall designate individuals to convene, within 30 days, to discuss how mutual funding goals for the

county providers are to be achieved.

(305 ILCS 5/15-11 new)

Sec. 15-11. Uses of State funds.

(a) At any point, if State revenues referenced in subsection (b) or (c) of Section 15-10 or additional State grants are disbursed to the Cook County Health and Hospitals System, all funds may be used only for the following:

(1) medical services provided at hospitals or clinics owned and operated by the Cook County Bureau of Health Services; or

(2) information technology to enhance billing capabilities for medical claiming and reimbursement.

(b) State funds may not be used for the following:

(1) non-clinical services, except services that may be required by accreditation bodies or State or federal regulatory or licensing authorities;

(2) non-clinical support staff, except as pursuant to paragraph (1) of this subsection; or

(3) capital improvements, other than investments in medical technology, except for capital improvements that may be required by accreditation bodies or State or federal regulatory or licensing authorities.

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