Rep. Robert Rita

Filed: 10/17/2017

AMENDMENT TO HOUSE BILL 174

AMENDMENT NO. _____. Amend House Bill 174 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Public Aid Code is amended by changing Sections 5A-2, 5A-12.2, 5A-12.4, 5A-12.5, and 14-12 as follows:

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

(Section scheduled to be repealed on July 1, 2018)

Sec. 5A-2. Assessment.

(a)(1) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal

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

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

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

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

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a

uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

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

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

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

Adjustment" means:

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

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

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under

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

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

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

(ii) the amount calculated under this subparagraph

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

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

(A) any differences between the actual payments issued or scheduled to be issued prior to June 30, 2018 as authorized in Section 5A-12.5 for the period of January 1, 2018 through June 30, 2018 and the estimated payments due and payable in the month of October 2017 multiplied by 6 as described in subparagraph (D); and

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

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

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D)

of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(c) (Blank).

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

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall

be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(f) Subject to federal approval and notwithstanding any other provision of this Code, for any redesign of any assessments authorized under this Section, the volume data used to redesign the distribution of payments shall include managed care organization denial payments or settlements between hospitals and managed care organizations.

(Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-2, eff. 3-26-15; 99-516, eff. 6-30-16.)

(305 ILCS 5/5A-12.2)

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

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2008, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act.

(a-5) The Illinois Department may, when practicable,

accelerate the schedule upon which payments authorized under this Section are made.

(b) Across-the-board inpatient adjustment.

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

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

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

(4) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois

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

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

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

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

(c) Outpatient adjustment.

(1) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois

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

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

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

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

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

(e) Capital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10%

(as calculated by the Department for the rate year 2007 disproportionate share determination) amounts as follows:

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

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

(f) Obstetrical care adjustment.

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

by Medicaid inpatient days) greater than 15% for State fiscal year 2005.

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

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

(g) Trauma adjustment.

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

(2) In addition to rates paid for inpatient hospital

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

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

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

(i) Crossover adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois general acute care hospital that had a ratio of crossover days to total inpatient days for medical assistance programs administered by the Department (utilizing information from 2005 paid claims) greater than 50%, and a case mix index

greater than the 65th percentile of case mix indices for all Illinois hospitals, a rate of $1,125 for each Medicaid inpatient day including crossover days.

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

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

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

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

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

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

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

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

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

"Base inpatient payments" means, for a given hospital, the

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

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

"Case mix index" means, for a given hospital, the sum of the DRG relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal

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

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

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

"Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services, as described in 89 Ill. Adm. Code

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

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

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

(q) (Blank).

(r) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any

rate of reimbursement for services or other payments in accordance with Section 5-5e.

(s) On or after January 1, 2016, and no less than annually thereafter, the Department shall increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in this Section and in Section 5A-12.4 by a uniform percentage on a regional basis to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. The aggregate amount of all increased capitation payments to all MCOs for a fiscal year shall be the amount needed to avoid reduction in payments authorized under Section 5A-15. Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published by the Department each year. Each MCO shall only expend the increased capitation payments it receives under this Section to support the availability of hospital services and to ensure access to hospital services, with such expenditures being made within 15 calendar days from when the MCO receives the increased capitation payment. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments made under this subsection shall be guaranteed by a surety bond obtained by the MCO in an amount established by the Department to approximate

one month's liability of payments authorized under this subsection. The Department may advance the payments guaranteed by the surety bond. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection.

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

(t) On or after July 1, 2014, the Department may increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in Section 5A-12.5 to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. Effective January 1, 2016, the Department shall increase capitation payments to MCOs to include the payments authorized under Section 5A-12.5 to preserve access to hospital services for recipients under the Illinois Medical Assistance Program by ensuring that the reimbursement provided for Affordable Care Act adults enrolled in a MCO is equivalent to the reimbursement provided for Affordable Care Act adults enrolled in a fee-for-service program. Payments to MCOs under this Section shall be consistent with actuarial certification and federal approval (which may be retrospectively determined) and shall be published by the Department each year. Each MCO shall only

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

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

(u) Subject to federal approval and notwithstanding any other provision of this Code, for any redesign of any payments authorized under this Section, the volume data used to redesign

the distribution of payments shall include managed care organization denial payments or settlements between hospitals and managed care organizations.

(Source: P.A. 98-651, eff. 6-16-14; 99-516, eff. 6-30-16.)

(305 ILCS 5/5A-12.4)

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

Sec. 5A-12.4. Hospital access improvement payments on or after June 10, 2012.

(a) Hospital access improvement payments. To preserve and improve access to hospital services, for hospital and physician services rendered on or after June 10, 2012, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the 7th State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under subsection (b-5) of Section 5A-2 of

this Article is determined to be a permissible tax under Title XIX of the Social Security Act. The Illinois Department shall take all actions necessary to implement the payments under this Section effective June 10, 2012, including but not limited to providing public notice pursuant to federal requirements, the filing of a State Plan amendment, and the adoption of administrative rules. For State fiscal year 2013, payments under this Section shall be increased by 21/365ths. The funding source for these additional payments shall be from the increased assessment under subsection (b-5) of Section 5A-2 that was received from hospital providers under Section 5A-4 for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012.

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

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

(1) For hospitals with a case mix index equal to or greater than the 80th percentile of case mix indices for all Illinois hospitals, $470 for each Medicaid general

acute care inpatient day of care provided by the hospital during State fiscal year 2009.

(2) For all other hospitals, $170 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

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

(1) For hospitals with a case mix index equal to or greater than the 50th percentile of case mix indices for all Illinois hospitals, $470 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

(2) For all other hospitals, $170 for each Medicaid general acute care inpatient day of care provided by the hospital during State fiscal year 2009.

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

(d) Dual-eligible adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois general acute care hospital that had a ratio of crossover days

to total inpatient days for programs under Title XIX of the Social Security Act administered by the Department (utilizing information from 2009 paid claims) greater than 50%, and a case mix index equal to or greater than the 75th percentile of case mix indices for all Illinois hospitals, a rate of $400 for each Medicaid inpatient day during State fiscal year 2009 including crossover days.

(e) Medicaid volume adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital that provided more than 10,000 Medicaid inpatient days of care in State fiscal year 2009, has a Medicaid inpatient utilization rate of at least 29.05% as calculated by the Department for the Rate Year 2011 Disproportionate Share determination, and is not eligible for Medicaid Percentage Adjustment payments in rate year 2011 an amount equal to $135 for each Medicaid inpatient day of care provided during State fiscal year 2009.

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

(g) Ambulatory service adjustment.

(1) In addition to the rates paid for outpatient

hospital services provided in the emergency department, the Department shall pay each Illinois hospital an amount equal to $105 multiplied by the hospital's outpatient ambulatory procedure listing services for categories 3A, 3B, and 3C for State fiscal year 2009.

(2) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding psychiatric hospital an amount equal to $200 multiplied by the hospital's ambulatory procedure listing services for category 5A for State fiscal year 2009.

(h) Specialty hospital adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois long term acute care hospital and each Illinois hospital devoted exclusively to the treatment of cancer, an amount equal to $700 multiplied by the hospital's outpatient ambulatory procedure listing services and by the hospital's end stage renal disease treatment services (including services provided to individuals eligible for both Medicaid and Medicare) provided for State fiscal year 2009.

(h-1) ER Safety Net Payments. In addition to rates paid for outpatient services, the Department shall pay to each Illinois general acute care hospital with an emergency room ratio equal to or greater than 55%, that is not eligible for Medicaid percentage adjustments payments in rate year 2011, with a case mix index equal to or greater than the 20th percentile, and that is not designated as a trauma center by the Illinois

Department of Public Health on July 1, 2011, as follows:

(1) Each hospital with an emergency room ratio equal to or greater than 74% shall receive a rate of $225 for each outpatient ambulatory procedure listing and end-stage renal disease treatment service provided for State fiscal year 2009.

(2) For all other hospitals, $65 shall be paid for each outpatient ambulatory procedure listing and end-stage renal disease treatment service provided for State fiscal year 2009.

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

(1) Physician services eligible for the adjustment payment are those provided by physicians employed by or who have a contract to provide services to patients of the following hospitals: (i) Illinois general acute care hospitals that provided at least 17,000 Medicaid inpatient days of care in State fiscal year 2009 and are eligible for Medicaid Percentage Adjustment Payments in rate year 2011; and (ii) Illinois freestanding children's hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(3)(A).

(2) The amount of the adjustment for each eligible hospital under this subsection (i) shall be determined by rule by the Department to spend a total pool of at least

$6,960,000 annually. This pool shall be allocated among the eligible hospitals based on the difference between the upper payment limit for what could have been paid under Medicaid for physician services provided during State fiscal year 2009 by physicians employed by or who had a contract with the hospital and the amount that was paid under Medicaid for such services, provided however, that in no event shall physicians at any individual hospital collectively receive an annual, aggregate adjustment in excess of $435,000, except that any amount that is not distributed to a hospital because of the upper payment limit shall be reallocated among the remaining eligible hospitals that are below the upper payment limitation, on a proportionate basis.

(i-5) For any children's hospital which did not charge for its services during the base period, the Department shall use data supplied by the hospital to determine payments using similar methodologies for freestanding children's hospitals under this Section or Section 5A-12.2.

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

(k) For purposes of this Section, the terms "Medicaid days", "ambulatory procedure listing services", and

"ambulatory procedure listing payments" do not include any days, charges, or services for which Medicare or a managed care organization reimbursed on a capitated basis was liable for payment, except where explicitly stated otherwise in this Section.

(l) Definitions. Unless the context requires otherwise or unless provided otherwise in this Section, the terms used in this Section for qualifying criteria and payment calculations shall have the same meanings as those terms have been given in the Illinois Department's administrative rules as in effect on October 1, 2011. Other terms shall be defined by the Illinois Department by rule.

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

"Case mix index" means, for a given hospital, the sum of the per admission (DRG) relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, divided by the total number of general acute care admissions for State fiscal year 2009, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

"Emergency room ratio" means, for a given hospital, a fraction, the denominator of which is the number of the hospital's outpatient ambulatory procedure listing and

end-stage renal disease treatment services provided for State fiscal year 2009 and the numerator of which is the hospital's outpatient ambulatory procedure listing services for categories 3A, 3B, and 3C for State fiscal year 2009.

"Medicaid inpatient day" means, for a given hospital, the sum of days of inpatient hospital days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2009 that was adjudicated by the Department through June 30, 2010.

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

"Outpatient end-stage renal disease treatment services" means, for a given hospital, the services, as described in 89 Ill. Adm. Code 148.140(c), provided to recipients of medical assistance under Title XIX of the federal Social Security Act,

excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in State fiscal year 2009 that were adjudicated by the Department through September 2, 2010.

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

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

(o) The Department of Healthcare and Family Services must submit a State Medicaid Plan Amendment to the Centers for Medicare and Medicaid Services to implement the payments under this Section.

(p) Subject to federal approval and notwithstanding any other provision of this Code, for any redesign of any payments

authorized under this Section, the volume data used to redesign the distribution of payments shall include managed care organization denial payments or settlements between hospitals and managed care organizations.

(Source: P.A. 97-688, eff. 6-14-12; 98-104, eff. 7-22-13; 98-463, eff. 8-16-13; 98-756, eff. 7-16-14.)

(305 ILCS 5/5A-12.5)

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

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

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

(b-5) Subject to federal approval and notwithstanding any other provision of this Code, for any redesign of any payments authorized under this Section, the volume data used to redesign the distribution of payments shall include managed care organization denial payments or settlements between hospitals and managed care organizations.

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

(Source: P.A. 98-651, eff. 6-16-14; 99-516, eff. 6-30-16.)

(305 ILCS 5/14-12)

Sec. 14-12. Hospital rate reform payment system. The hospital payment system pursuant to Section 14-11 of this Article shall be as follows:

(a) Inpatient hospital services. Effective for discharges on and after July 1, 2014, reimbursement for inpatient general acute care services shall utilize the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, version 30, distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. Initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 30.0 adjusted for the

Illinois experience.

(2) The Department shall establish a statewide-standardized amount to be used in the inpatient reimbursement system. The Department shall publish these amounts on its website no later than 10 calendar days prior to their effective date.

(3) In addition to the statewide-standardized amount, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid providers or services for trauma, transplantation services, perinatal care, and Graduate Medical Education (GME).

(4) The Department shall develop add-on payments to account for exceptionally costly inpatient stays, consistent with Medicare outlier principles. Outlier fixed loss thresholds may be updated to control for excessive growth in outlier payments no more frequently than on an annual basis, but at least triennially. Upon updating the fixed loss thresholds, the Department shall be required to update base rates within 12 months.

(5) The Department shall define those hospitals or distinct parts of hospitals that shall be exempt from the APR-DRG reimbursement system established under this Section. The Department shall publish these hospitals' inpatient rates on its website no later than 10 calendar days prior to their effective date.

(6) Beginning July 1, 2014 and ending on June 30, 2018,

in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals.

(7) Beginning July 1, 2014 and ending on June 30, 2018, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(b) Outpatient hospital services. Effective for dates of service on and after July 1, 2014, reimbursement for outpatient services shall utilize the Enhanced Ambulatory Procedure Grouping (E-APG) software, version 3.7 distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. The initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 3.7.

(2) The Department shall establish service specific statewide-standardized amounts to be used in the reimbursement system.

(A) The initial statewide standardized amounts, with the labor portion adjusted by the Calendar Year

2013 Medicare Outpatient Prospective Payment System wage index with reclassifications, shall be published by the Department on its website no later than 10 calendar days prior to their effective date.

(B) The Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F. The EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments under Section 5A-12.4 of this Code net of the associated tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals.

(c) In consultation with the hospital community, the Department is authorized to replace 89 Ill. Admin. Code 152.150 as published in 38 Ill. Reg. 4980 through 4986 within 12 months of the effective date of this amendatory Act of the 98th General Assembly. If the Department does not replace these rules within 12 months of the effective date of this amendatory

Act of the 98th General Assembly, the rules in effect for 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall remain in effect until modified by rule by the Department. Nothing in this subsection shall be construed to mandate that the Department file a replacement rule.

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the Department. To help provide an orderly and predictable transition to the new reimbursement systems and to preserve and enhance access to the hospital services during this transition, the Department shall allocate a transitional hospital access pool of at least $290,000,000 annually so that transitional hospital access payments are made to hospitals.

(1) After the transition period, the Department may begin incorporating the transitional hospital access pool into the base rate structure.

(2) After the transition period, if the Department reduces payments from the transitional hospital access pool, it shall increase base rates, develop new adjustors, adjust current adjustors, develop new hospital access payments based on updated information, or any combination thereof by an amount equal to the decreases proposed in the transitional hospital access pool payments, ensuring that the entire transitional hospital access pool amount shall

continue to be used for hospital payments.

Subject to federal approval and notwithstanding any other provision of this Code, for any redesign of transitional hospital access payments authorized under this Section, the volume data used to redesign the distribution of payments shall include managed care organization denial payments or settlements between hospitals and managed care organizations.

(e) Beginning 36 months after initial implementation, the Department shall update the reimbursement components in subsections (a) and (b), including standardized amounts and weighting factors, and at least triennially and no more frequently than annually thereafter. The Department shall publish these updates on its website no later than 30 calendar days prior to their effective date.

(f) Continuation of supplemental payments. Any supplemental payments authorized under Illinois Administrative Code 148 effective January 1, 2014 and that continue during the period of July 1, 2014 through December 31, 2014 shall remain in effect as long as the assessment imposed by Section 5A-2 is in effect.

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under Section 5-5b.1, any updates to the system shall not result in any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in

any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors including but not limited to the number of individuals in the medical assistance program and the severity of illness of the individuals.

(h) The Department shall have the authority to modify by rulemaking any changes to the rates or methodologies in this Section as required by the federal government to obtain federal financial participation for expenditures made under this Section.

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the

Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

(Source: P.A. 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

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