



Rep. Robert Rita

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1 AMENDMENT TO HOUSE BILL 174

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 174 by replacing  
3 everything after the enacting clause with the following:

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

7 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

8 (Section scheduled to be repealed on July 1, 2018)

9 Sec. 5A-2. Assessment.

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

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

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

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

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

7 (b) (Blank).

8 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the  
9 portion of State fiscal year 2012, beginning June 10, 2012  
10 through June 30, 2012, and for State fiscal years 2013 through  
11 2018, an annual assessment on outpatient services is imposed on  
12 each hospital provider in an amount equal to .008766 multiplied  
13 by the hospital's outpatient gross revenue, provided, however,  
14 that the amount of .008766 shall be increased by a uniform  
15 percentage to generate an amount equal to 25% of the State  
16 share of the payments authorized under Section 5A-12.5, with  
17 such increase only taking effect upon the date that a State  
18 share for such payments is required under federal law. For the  
19 period beginning June 10, 2012 through June 30, 2012, the  
20 annual assessment on outpatient services shall be prorated by  
21 multiplying the assessment amount by a fraction, the numerator  
22 of which is 21 days and the denominator of which is 365 days.  
23 For the period of April through June 2015, the amount of  
24 .008766 used to calculate the assessment under this paragraph  
25 shall, by emergency rule under subsection (s) of Section 5-45  
26 of the Illinois Administrative Procedure Act, be increased by a

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

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

11 For the portion of State fiscal year 2012, beginning June  
12 10, 2012 through June 30, 2012, and State fiscal years 2013  
13 through 2018, a hospital's outpatient gross revenue shall be  
14 determined using the most recent data available from each  
15 hospital's 2009 Medicare cost report as contained in the  
16 Healthcare Cost Report Information System file, for the quarter  
17 ending on June 30, 2011, without regard to any subsequent  
18 adjustments or changes to such data. If a hospital's 2009  
19 Medicare cost report is not contained in the Healthcare Cost  
20 Report Information System, then the Department may obtain the  
21 hospital provider's outpatient gross revenue from any source  
22 available, including, but not limited to, records maintained by  
23 the hospital provider, which may be inspected at all times  
24 during business hours of the day by the Department or its duly  
25 authorized agents and employees.

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

1 Adjustment" means:

2 (A) For the period of July 1, 2016 through December 31,  
3 2016, the product of .19125 multiplied by the sum of the  
4 fee-for-service payments to hospitals as authorized under  
5 Section 5A-12.5 and the adjustments authorized under  
6 subsection (t) of Section 5A-12.2 to managed care  
7 organizations for hospital services due and payable in the  
8 month of April 2016 multiplied by 6.

9 (B) For the period of January 1, 2017 through June 30,  
10 2017, the product of .19125 multiplied by the sum of the  
11 fee-for-service payments to hospitals as authorized under  
12 Section 5A-12.5 and the adjustments authorized under  
13 subsection (t) of Section 5A-12.2 to managed care  
14 organizations for hospital services due and payable in the  
15 month of October 2016 multiplied by 6, except that the  
16 amount calculated under this subparagraph (B) shall be  
17 adjusted, either positively or negatively, to account for  
18 the difference between the actual payments issued under  
19 Section 5A-12.5 for the period beginning July 1, 2016  
20 through December 31, 2016 and the estimated payments due  
21 and payable in the month of April 2016 multiplied by 6 as  
22 described in subparagraph (A).

23 (C) For the period of July 1, 2017 through December 31,  
24 2017, the product of .19125 multiplied by the sum of the  
25 fee-for-service payments to hospitals as authorized under  
26 Section 5A-12.5 and the adjustments authorized under

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

11 (D) For the period of January 1, 2018 through June 30,  
12 2018, the product of .19125 multiplied by the sum of the  
13 fee-for-service payments to hospitals as authorized under  
14 Section 5A-12.5 and the adjustments authorized under  
15 subsection (t) of Section 5A-12.2 to managed care  
16 organizations for hospital services due and payable in the  
17 month of October 2017 multiplied by 6, except that:

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

26 (ii) the amount calculated under this subparagraph

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

5 (2) The Department shall complete and apply a final  
6 reconciliation of the ACA Assessment Adjustment prior to June  
7 30, 2018 to account for:

8 (A) any differences between the actual payments issued  
9 or scheduled to be issued prior to June 30, 2018 as  
10 authorized in Section 5A-12.5 for the period of January 1,  
11 2018 through June 30, 2018 and the estimated payments due  
12 and payable in the month of October 2017 multiplied by 6 as  
13 described in subparagraph (D); and

14 (B) any difference between the estimated  
15 fee-for-service payments under subsection (b) of Section  
16 5A-12.5 and the amount of such payments that are actually  
17 scheduled to be paid.

18 The Department shall notify hospitals of any additional  
19 amounts owed or reduction credits to be applied to the June  
20 2018 ACA Assessment Adjustment. This is to be considered the  
21 final reconciliation for the ACA Assessment Adjustment.

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

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

6 (4) The increases authorized under paragraph (2) of  
7 subsection (a) and paragraph (2) of subsection (b-5) shall be  
8 limited to the federally required State share of the total  
9 payments authorized under Section 5A-12.5 if the sum of such  
10 payments yields an annualized amount equal to or less than  
11 \$450,000,000, or if the adjustments authorized under  
12 subsection (t) of Section 5A-12.2 are found not to be  
13 actuarially sound; however, this limitation shall not apply to  
14 the fee-for-service payments described in subsection (b) of  
15 Section 5A-12.5.

16 (c) (Blank).

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

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



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

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

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

3 (305 ILCS 5/5A-12.2)

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

5 Sec. 5A-12.2. Hospital access payments on or after July 1,  
6 2008.

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

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

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

3 (b) Across-the-board inpatient adjustment.

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

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

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

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

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

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

13 (i) For freestanding children's hospitals as  
14 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5  
15 multiplied by the hospital's pediatric inpatient  
16 adjustment payment required under 89 Ill. Adm. Code  
17 148.298, as in effect for State fiscal year 2008.

18 (ii) For hospitals other than freestanding  
19 children's hospitals as defined in 89 Ill. Adm. Code  
20 149.50(c)(3)(B), 1.0 multiplied by the hospital's  
21 pediatric inpatient adjustment payment required under  
22 89 Ill. Adm. Code 148.298, as in effect for State  
23 fiscal year 2008.

24 (c) Outpatient adjustment.

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

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

5 (2) In addition to the rates paid for outpatient  
6 hospital services, the Department shall pay each Illinois  
7 freestanding psychiatric hospital an amount equal to 3.25  
8 multiplied by the hospital's ambulatory procedure listing  
9 payments for category 5b, as defined in 89 Ill. Adm. Code  
10 148.140(b)(1)(E), for State fiscal year 2005.

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

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

20 (2) For hospitals with a case mix index less than the  
21 85th percentile of hospital case mix indices, \$100 for each  
22 Medicaid inpatient day of care provided during that period.

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

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

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

12 (2) For each Illinois general acute care hospital that  
13 has a Medicaid inpatient utilization rate of at least  
14 36.94% and whose capital cost is less than the 75th  
15 percentile of the capital costs of all Illinois hospitals,  
16 the amount of such payment shall equal the hospital's  
17 Medicaid inpatient days multiplied by the difference  
18 between the capital costs at the 75th percentile of the  
19 capital costs of all Illinois hospitals and the hospital's  
20 capital costs.

21 (f) Obstetrical care adjustment.

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

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

3 (2) In addition to rates paid for inpatient hospital  
4 services, the Department shall pay \$1,350 for each Medicaid  
5 obstetrical day of care provided in State fiscal year 2005  
6 by each Illinois general acute care hospital that was  
7 designated a level III perinatal center as of December 31,  
8 2006, and that had a case mix index equal to or greater  
9 than the 45th percentile of the case mix indices for all  
10 level III perinatal centers.

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

19 (g) Trauma adjustment.

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

26 (2) In addition to rates paid for inpatient hospital

1 services, the Department shall pay \$400 for each Medicaid  
2 acute inpatient day of care provided in State fiscal year  
3 2005 by each Illinois general acute care hospital that was  
4 designated a level II trauma center, as defined in 89 Ill.  
5 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,  
6 2007.

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

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

21 (i) Crossover adjustment. In addition to rates paid for  
22 inpatient services, the Department shall pay each Illinois  
23 general acute care hospital that had a ratio of crossover days  
24 to total inpatient days for medical assistance programs  
25 administered by the Department (utilizing information from  
26 2005 paid claims) greater than 50%, and a case mix index



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

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

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

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

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

1           (k) For purposes of this Section, a hospital that is  
2 enrolled to provide Medicaid services during State fiscal year  
3 2005 shall have its utilization and associated reimbursements  
4 annualized prior to the payment calculations being performed  
5 under this Section.

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

13           (m) For purposes of this Section, in determining the  
14 percentile ranking of an Illinois hospital's case mix index or  
15 capital costs, hospitals described in subsection (b) of Section  
16 5A-3 shall be excluded from the ranking.

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

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

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

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

8 "Capital costs" means, for a given hospital, the total  
9 capital costs determined using the most recent 2005 Medicare  
10 cost report as contained in the Healthcare Cost Report  
11 Information System file, for the quarter ending on December 31,  
12 2006, divided by the total inpatient days from the same cost  
13 report to calculate a capital cost per day. The resulting  
14 capital cost per day is inflated to the midpoint of State  
15 fiscal year 2009 utilizing the national hospital market price  
16 proxies (DRI) hospital cost index. If a hospital's 2005  
17 Medicare cost report is not contained in the Healthcare Cost  
18 Report Information System, the Department may obtain the data  
19 necessary to compute the hospital's capital costs from any  
20 source available, including, but not limited to, records  
21 maintained by the hospital provider, which may be inspected at  
22 all times during business hours of the day by the Illinois  
23 Department or its duly authorized agents and employees.

24 "Case mix index" means, for a given hospital, the sum of  
25 the DRG relative weighting factors in effect on January 1,  
26 2005, for all general acute care admissions for State fiscal

1 year 2005, excluding Medicare crossover admissions and  
2 transplant admissions reimbursed under 89 Ill. Adm. Code  
3 148.82, divided by the total number of general acute care  
4 admissions for State fiscal year 2005, excluding Medicare  
5 crossover admissions and transplant admissions reimbursed  
6 under 89 Ill. Adm. Code 148.82.

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

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

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

1 148.140(b), provided to recipients of medical assistance under  
2 Title XIX of the federal Social Security Act, excluding  
3 payments for individuals eligible for Medicare under Title  
4 XVIII of the Act (Medicaid/Medicare crossover days), as  
5 tabulated from the Department's paid claims data for services  
6 occurring in State fiscal year 2005 that were adjudicated by  
7 the Department through March 23, 2007.

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

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

23 (q) (Blank).

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

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

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

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

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

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

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

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

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



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

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

5 (305 ILCS 5/5A-12.4)

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

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

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

1 this Article is determined to be a permissible tax under Title  
2 XIX of the Social Security Act. The Illinois Department shall  
3 take all actions necessary to implement the payments under this  
4 Section effective June 10, 2012, including but not limited to  
5 providing public notice pursuant to federal requirements, the  
6 filing of a State Plan amendment, and the adoption of  
7 administrative rules. For State fiscal year 2013, payments  
8 under this Section shall be increased by 21/365ths. The funding  
9 source for these additional payments shall be from the  
10 increased assessment under subsection (b-5) of Section 5A-2  
11 that was received from hospital providers under Section 5A-4  
12 for the portion of State fiscal year 2012 beginning June 10,  
13 2012 through June 30, 2012.

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

17 (b) Magnet and perinatal hospital adjustment. In addition  
18 to rates paid for inpatient hospital services, the Department  
19 shall pay to each Illinois general acute care hospital that, as  
20 of August 25, 2011, was recognized as a Magnet hospital by the  
21 American Nurses Credentialing Center and that, as of September  
22 14, 2011, was designated as a level III perinatal center  
23 amounts as follows:

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

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

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

6 (c) Trauma level II adjustment. In addition to rates paid  
7 for inpatient hospital services, the Department shall pay to  
8 each Illinois general acute care hospital that, as of July 1,  
9 2011, was designated as a level II trauma center amounts as  
10 follows:

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

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

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

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

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

8 (e) Medicaid volume adjustment. In addition to rates paid  
9 for inpatient hospital services, the Department shall pay to  
10 each Illinois general acute care hospital that provided more  
11 than 10,000 Medicaid inpatient days of care in State fiscal  
12 year 2009, has a Medicaid inpatient utilization rate of at  
13 least 29.05% as calculated by the Department for the Rate Year  
14 2011 Disproportionate Share determination, and is not eligible  
15 for Medicaid Percentage Adjustment payments in rate year 2011  
16 an amount equal to \$135 for each Medicaid inpatient day of care  
17 provided during State fiscal year 2009.

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

25 (g) Ambulatory service adjustment.

26 (1) In addition to the rates paid for outpatient

1 hospital services provided in the emergency department,  
2 the Department shall pay each Illinois hospital an amount  
3 equal to \$105 multiplied by the hospital's outpatient  
4 ambulatory procedure listing services for categories 3A,  
5 3B, and 3C for State fiscal year 2009.

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

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

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

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

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

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

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

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

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

1           \$6,960,000 annually. This pool shall be allocated among the  
2           eligible hospitals based on the difference between the  
3           upper payment limit for what could have been paid under  
4           Medicaid for physician services provided during State  
5           fiscal year 2009 by physicians employed by or who had a  
6           contract with the hospital and the amount that was paid  
7           under Medicaid for such services, provided however, that in  
8           no event shall physicians at any individual hospital  
9           collectively receive an annual, aggregate adjustment in  
10          excess of \$435,000, except that any amount that is not  
11          distributed to a hospital because of the upper payment  
12          limit shall be reallocated among the remaining eligible  
13          hospitals that are below the upper payment limitation, on a  
14          proportionate basis.

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

20          (j) For purposes of this Section, a hospital that is  
21          enrolled to provide Medicaid services during State fiscal year  
22          2009 shall have its utilization and associated reimbursements  
23          annualized prior to the payment calculations being performed  
24          under this Section.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

7 (305 ILCS 5/5A-12.5)

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

10 (a) The Department shall, subject to federal approval,  
11 mirror the Medical Assistance hospital reimbursement  
12 methodology for Affordable Care Act adults who are enrolled  
13 under a fee-for-service or capitated managed care program,  
14 including hospital access payments as defined in Section  
15 5A-12.2 of this Article and hospital access improvement  
16 payments as defined in Section 5A-12.4 of this Article, in  
17 compliance with the equivalent rate provisions of the  
18 Affordable Care Act.

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

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

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

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

12       (305 ILCS 5/14-12)

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

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

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

1 Illinois experience.

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

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

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

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

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

1 in addition to the statewide-standardized amount, the  
2 Department shall develop an adjustor to adjust the rate of  
3 reimbursement for safety-net hospitals defined in Section  
4 5-5e.1 of this Code excluding pediatric hospitals.

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

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

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

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

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

1           2013 Medicare Outpatient Prospective Payment System  
2           wage index with reclassifications, shall be published  
3           by the Department on its website no later than 10  
4           calendar days prior to their effective date.

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

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

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

1 Act of the 98th General Assembly, the rules in effect for  
2 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall  
3 remain in effect until modified by rule by the Department.  
4 Nothing in this subsection shall be construed to mandate that  
5 the Department file a replacement rule.

6 (d) Transition period. There shall be a transition period  
7 to the reimbursement systems authorized under this Section that  
8 shall begin on the effective date of these systems and continue  
9 until June 30, 2018, unless extended by rule by the Department.  
10 To help provide an orderly and predictable transition to the  
11 new reimbursement systems and to preserve and enhance access to  
12 the hospital services during this transition, the Department  
13 shall allocate a transitional hospital access pool of at least  
14 \$290,000,000 annually so that transitional hospital access  
15 payments are made to hospitals.

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

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



1 continue to be used for hospital payments.

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

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

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

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

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

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

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

1 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499  
2 (Specialized Health Care Delivery Systems) and 6505 (Hospital  
3 Services).  
4 (Source: P.A. 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

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