HB4099

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4099

by Rep. Robert Rita

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5A-2 from Ch. 23, par. 5A-2
305 ILCS 5/5A-12.2
305 ILCS 5/5A-12.4
305 ILCS 5/5A-12.5
305 ILCS 5/14-12

Amends the Illinois Public Aid Code. Provides that, subject to federal approval, for any redesign of certain hospital assessments and payments authorized under the Code, the volume data used to redesign the distribution of hospital payments shall include managed care organization denial payments or settlements between hospitals and managed care organizations. Effective immediately.

LRB100 14594 KTG 29391 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

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8 (Section scheduled to be repealed on July 1, 2018)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
17 to 75% of the State share of the payments authorized under
18 Section 5A-12.5, with such increase only taking effect upon the
19 date that a State share for such payments is required under
20 federal law. For the period of April through June 2015, the
21 amount of $218.38 used to calculate the assessment under this
22 paragraph shall, by emergency rule under subsection (s) of
23 Section 5-45 of the Illinois Administrative Procedure Act, be

1 increased by a uniform percentage to generate $20,250,000 in
2 the aggregate for that period from all hospitals subject to the
3 annual assessment 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 $218.38
8 shall be increased by a uniform percentage to generate an
9 amount equal to 75% of the ACA Assessment Adjustment, as
10 defined in subsection (b-6) of this Section.

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

26 (b) (Blank).

1 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the
2 portion of State fiscal year 2012, beginning June 10, 2012
3 through June 30, 2012, and for State fiscal years 2013 through
4 2018, an annual assessment on outpatient services is imposed on
5 each hospital provider in an amount equal to .008766 multiplied
6 by the hospital's outpatient gross revenue, provided, however,
7 that the amount of .008766 shall be increased by a uniform
8 percentage to generate an amount equal to 25% of the State
9 share of the payments authorized under Section 5A-12.5, with
10 such increase only taking effect upon the date that a State
11 share for such payments is required under federal law. For the
12 period beginning June 10, 2012 through June 30, 2012, the
13 annual assessment on outpatient services shall be prorated by
14 multiplying the assessment amount by a fraction, the numerator
15 of which is 21 days and the denominator of which is 365 days.
16 For the period of April through June 2015, the amount of
17 .008766 used to calculate the assessment under this paragraph
18 shall, by emergency rule under subsection (s) of Section 5-45
19 of the Illinois Administrative Procedure Act, be increased by a
20 uniform percentage to generate $6,750,000 in the aggregate for
21 that period from all hospitals subject to the annual assessment
22 under this paragraph.

23 (2) In addition to any other assessments imposed under this
24 Article, effective July 1, 2016 and semi-annually thereafter
25 through June 2018, in addition to any federally required State
26 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

1 month of April 2016 multiplied by 6.
2 (B) For the period of January 1, 2017 through June 30,
3 2017, 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 October 2016 multiplied by 6, except that the
9 amount calculated under this subparagraph (B) shall be
10 adjusted, either positively or negatively, to account for
11 the difference between the actual payments issued under
12 Section 5A-12.5 for the period beginning July 1, 2016
13 through December 31, 2016 and the estimated payments due
14 and payable in the month of April 2016 multiplied by 6 as
15 described in subparagraph (A).
16 (C) For the period of July 1, 2017 through December 31,
17 2017, the product of .19125 multiplied by the sum of the
18 fee-for-service payments to hospitals as authorized under
19 Section 5A-12.5 and the adjustments authorized under
20 subsection (t) of Section 5A-12.2 to managed care
21 organizations for hospital services due and payable in the
22 month of April 2017 multiplied by 6, except that the amount
23 calculated under this subparagraph (C) shall be adjusted,
24 either positively or negatively, to account for the
25 difference between the actual payments issued under
26 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:

1 (A) any differences between the actual payments issued
2 or scheduled to be issued prior to June 30, 2018 as
3 authorized in Section 5A-12.5 for the period of January 1,
4 2018 through June 30, 2018 and the estimated payments due
5 and payable in the month of October 2017 multiplied by 6 as
6 described in subparagraph (D); and
7 (B) any difference between the estimated
8 fee-for-service payments under subsection (b) of Section
9 5A-12.5 and the amount of such payments that are actually
10 scheduled to be paid.
11 The Department shall notify hospitals of any additional
12 amounts owed or reduction credits to be applied to the June
13 2018 ACA Assessment Adjustment. This is to be considered the
14 final reconciliation for the ACA Assessment Adjustment.
15 (3) Notwithstanding any other provision of this Section, if
16 for any reason the scheduled payments under subsection (b) of
17 Section 5A-12.5 are not issued in full by the final day of the
18 period authorized under subsection (b) of Section 5A-12.5,
19 funds collected from each hospital pursuant to subparagraph (D)
20 of paragraph (1) and pursuant to paragraph (2), attributable to
21 the scheduled payments authorized under subsection (b) of
22 Section 5A-12.5 that are not issued in full by the final day of
23 the period attributable to each payment authorized under
24 subsection (b) of Section 5A-12.5, shall be refunded.
25 (4) The increases authorized under paragraph (2) of
26 subsection (a) and paragraph (2) of subsection (b-5) shall be

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

9 (c) (Blank).

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

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

1 submission, that State Plan Amendment shall be submitted in a
2 timely manner for review by the Centers for Medicare and
3 Medicaid Services of the United States Department of Health and
4 Human Services and subject to approval by the Centers for
5 Medicare and Medicaid Services of the United States Department
6 of Health and Human Services. No such plan shall become
7 effective without approval by the Illinois General Assembly by
8 the enactment into law of related legislation. Notwithstanding
9 any other provision of this Section, the Department is
10 authorized to adopt rules to reduce the rate of any annual
11 assessment imposed under this Section. Any such rules may be
12 adopted by the Department under Section 5-50 of the Illinois
13 Administrative Procedure Act.

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

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

22 (305 ILCS 5/5A-12.2)
23 (Section scheduled to be repealed on July 1, 2018)
24 Sec. 5A-12.2. Hospital access payments on or after July 1,
25 2008.

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

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

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

23 (1) In addition to rates paid for inpatient hospital
24 services, the Department shall pay to each Illinois general
25 acute care hospital an amount equal to 40% of the total
26 base inpatient payments paid to the hospital for services

1 provided in State fiscal year 2005.
2 (2) In addition to rates paid for inpatient hospital
3 services, the Department shall pay to each freestanding
4 Illinois specialty care hospital as defined in 89 Ill. Adm.
5 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
6 the total base inpatient payments paid to the hospital for
7 services provided in State fiscal year 2005.
8 (3) In addition to rates paid for inpatient hospital
9 services, the Department shall pay to each freestanding
10 Illinois rehabilitation or psychiatric hospital an amount
11 equal to $1,000 per Medicaid inpatient day multiplied by
12 the increase in the hospital's Medicaid inpatient
13 utilization ratio (determined using the positive
14 percentage change from the rate year 2005 Medicaid
15 inpatient utilization ratio to the rate year 2007 Medicaid
16 inpatient utilization ratio, as calculated by the
17 Department for the disproportionate share determination).
18 (4) In addition to rates paid for inpatient hospital
19 services, the Department shall pay to each Illinois
20 children's hospital an amount equal to 20% of the total
21 base inpatient payments paid to the hospital for services
22 provided in State fiscal year 2005 and an additional amount
23 equal to 20% of the base inpatient payments paid to the
24 hospital for psychiatric services provided in State fiscal
25 year 2005.
26 (5) In addition to rates paid for inpatient hospital

1 services, the Department shall pay to each Illinois
2 hospital eligible for a pediatric inpatient adjustment
3 payment under 89 Ill. Adm. Code 148.298, as in effect for
4 State fiscal year 2007, a supplemental pediatric inpatient
5 adjustment payment equal to:

6 (i) For freestanding children's hospitals as
7 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
8 multiplied by the hospital's pediatric inpatient
9 adjustment payment required under 89 Ill. Adm. Code
10 148.298, as in effect for State fiscal year 2008.

11 (ii) For hospitals other than freestanding
12 children's hospitals as defined in 89 Ill. Adm. Code
13 149.50(c)(3)(B), 1.0 multiplied by the hospital's
14 pediatric inpatient adjustment payment required under
15 89 Ill. Adm. Code 148.298, as in effect for State
16 fiscal year 2008.

17 (c) Outpatient adjustment.

18 (1) In addition to the rates paid for outpatient
19 hospital services, the Department shall pay each Illinois
20 hospital an amount equal to 2.2 multiplied by the
21 hospital's ambulatory procedure listing payments for
22 categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code
23 148.140(b), for State fiscal year 2005.

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

1 hospital's Medicaid inpatient days multiplied by the
2 difference between the capital costs at the 60th percentile
3 of the capital costs of all Illinois hospitals and the
4 hospital's capital costs.
5 (2) For each Illinois general acute care hospital that
6 has a Medicaid inpatient utilization rate of at least
7 36.94% and whose capital cost is less than the 75th
8 percentile of the capital costs of all Illinois hospitals,
9 the amount of such payment shall equal the hospital's
10 Medicaid inpatient days multiplied by the difference
11 between the capital costs at the 75th percentile of the
12 capital costs of all Illinois hospitals and the hospital's
13 capital costs.
14 (f) Obstetrical care adjustment.
15 (1) In addition to rates paid for inpatient hospital
16 services, the Department shall pay $1,500 for each Medicaid
17 obstetrical day of care provided in State fiscal year 2005
18 by each Illinois rural hospital that had a Medicaid
19 obstetrical percentage (Medicaid obstetrical days divided
20 by Medicaid inpatient days) greater than 15% for State
21 fiscal year 2005.
22 (2) In addition to rates paid for inpatient hospital
23 services, the Department shall pay $1,350 for each Medicaid
24 obstetrical day of care provided in State fiscal year 2005
25 by each Illinois general acute care hospital that was
26 designated a level III perinatal center as of December 31,

1 2006, and that had a case mix index equal to or greater
2 than the 45th percentile of the case mix indices for all
3 level III perinatal centers.
4 (3) In addition to rates paid for inpatient hospital
5 services, the Department shall pay $900 for each Medicaid
6 obstetrical day of care provided in State fiscal year 2005
7 by each Illinois general acute care hospital that was
8 designated a level II or II+ perinatal center as of
9 December 31, 2006, and that had a case mix index equal to
10 or greater than the 35th percentile of the case mix indices
11 for all level II and II+ perinatal centers.
12 (g) Trauma adjustment.
13 (1) In addition to rates paid for inpatient hospital
14 services, the Department shall pay each Illinois general
15 acute care hospital designated as a trauma center as of
16 July 1, 2007, a payment equal to 3.75 multiplied by the
17 hospital's State fiscal year 2005 Medicaid capital
18 payments.
19 (2) In addition to rates paid for inpatient hospital
20 services, the Department shall pay $400 for each Medicaid
21 acute inpatient day of care provided in State fiscal year
22 2005 by each Illinois general acute care hospital that was
23 designated a level II trauma center, as defined in 89 Ill.
24 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,
25 2007.
26 (3) In addition to rates paid for inpatient hospital

1 services, the Department shall pay $235 for each Illinois
2 Medicaid acute inpatient day of care provided in State
3 fiscal year 2005 by each level I pediatric trauma center
4 located outside of Illinois that had more than 8,000
5 Illinois Medicaid inpatient days in State fiscal year 2005.
6 (h) Supplemental tertiary care adjustment. In addition to
7 rates paid for inpatient services, the Department shall pay to
8 each Illinois hospital eligible for tertiary care adjustment
9 payments under 89 Ill. Adm. Code 148.296, as in effect for
10 State fiscal year 2007, a supplemental tertiary care adjustment
11 payment equal to the tertiary care adjustment payment required
12 under 89 Ill. Adm. Code 148.296, as in effect for State fiscal
13 year 2007.
14 (i) Crossover adjustment. In addition to rates paid for
15 inpatient services, the Department shall pay each Illinois
16 general acute care hospital that had a ratio of crossover days
17 to total inpatient days for medical assistance programs
18 administered by the Department (utilizing information from
19 2005 paid claims) greater than 50%, and a case mix index
20 greater than the 65th percentile of case mix indices for all
21 Illinois hospitals, a rate of $1,125 for each Medicaid
22 inpatient day including crossover days.
23 (j) Magnet hospital adjustment. In addition to rates paid
24 for inpatient hospital services, the Department shall pay to
25 each Illinois general acute care hospital and each Illinois
26 freestanding children's hospital that, as of February 1, 2008,

1 was recognized as a Magnet hospital by the American Nurses
2 Credentialing Center and that had a case mix index greater than
3 the 75th percentile of case mix indices for all Illinois
4 hospitals amounts as follows:
5 (1) For hospitals located in a county whose eligibility
6 growth factor is greater than the mean, $450 multiplied by
7 the eligibility growth factor for the county in which the
8 hospital is located for each Medicaid inpatient day of care
9 provided by the hospital during State fiscal year 2005.
10 (2) For hospitals located in a county whose eligibility
11 growth factor is less than or equal to the mean, $225
12 multiplied by the eligibility growth factor for the county
13 in which the hospital is located for each Medicaid
14 inpatient day of care provided by the hospital during State
15 fiscal year 2005.
16 For purposes of this subsection, "eligibility growth
17 factor" means the percentage by which the number of Medicaid
18 recipients in the county increased from State fiscal year 1998
19 to State fiscal year 2005.
20 (k) For purposes of this Section, a hospital that is
21 enrolled to provide Medicaid services during State fiscal year
22 2005 shall have its utilization and associated reimbursements
23 annualized prior to the payment calculations being performed
24 under this Section.
25 (l) For purposes of this Section, the terms "Medicaid
26 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.

1 "Capital costs" means, for a given hospital, the total
2 capital costs determined using the most recent 2005 Medicare
3 cost report as contained in the Healthcare Cost Report
4 Information System file, for the quarter ending on December 31,
5 2006, divided by the total inpatient days from the same cost
6 report to calculate a capital cost per day. The resulting
7 capital cost per day is inflated to the midpoint of State
8 fiscal year 2009 utilizing the national hospital market price
9 proxies (DRI) hospital cost index. If a hospital's 2005
10 Medicare cost report is not contained in the Healthcare Cost
11 Report Information System, the Department may obtain the data
12 necessary to compute the hospital's capital costs from any
13 source available, including, but not limited to, records
14 maintained by the hospital provider, which may be inspected at
15 all times during business hours of the day by the Illinois
16 Department or its duly authorized agents and employees.

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

26 "Medicaid inpatient day" means, for a given hospital, the

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

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

17 "Outpatient ambulatory procedure listing payments" means,
18 for a given hospital, the sum of payments for ambulatory
19 procedure listing services, as described in 89 Ill. Adm. Code
20 148.140(b), provided to recipients of medical assistance under
21 Title XIX of the federal Social Security Act, excluding
22 payments for individuals eligible for Medicare under Title
23 XVIII of the Act (Medicaid/Medicare crossover days), as
24 tabulated from the Department's paid claims data for services
25 occurring in State fiscal year 2005 that were adjudicated by
26 the Department through March 23, 2007.

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

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

16 (q) (Blank).

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

22 (s) On or after January 1, 2016, and no less than annually
23 thereafter, the Department shall increase capitation payments
24 to capitated managed care organizations (MCOs) to equal the
25 aggregate reduction of payments made in this Section and in
26 Section 5A-12.4 by a uniform percentage on a regional basis to

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

1 As used in this subsection, "MCO" means an entity which
2 contracts with the Department to provide services where payment
3 for medical services is made on a capitated basis.
4 (t) On or after July 1, 2014, the Department may increase
5 capitation payments to capitated managed care organizations
6 (MCOs) to equal the aggregate reduction of payments made in
7 Section 5A-12.5 to preserve access to hospital services for
8 recipients under the Illinois Medical Assistance Program.
9 Effective January 1, 2016, the Department shall increase
10 capitation payments to MCOs to include the payments authorized
11 under Section 5A-12.5 to preserve access to hospital services
12 for recipients under the Illinois Medical Assistance Program by
13 ensuring that the reimbursement provided for Affordable Care
14 Act adults enrolled in a MCO is equivalent to the reimbursement
15 provided for Affordable Care Act adults enrolled in a
16 fee-for-service program. Payments to MCOs under this Section
17 shall be consistent with actuarial certification and federal
18 approval (which may be retrospectively determined) and shall be
19 published by the Department each year. Each MCO shall only
20 expend the increased capitation payments it receives under this
21 Section to support the availability of hospital services and to
22 ensure access to hospital services, with such expenditures
23 being made within 15 calendar days from when the MCO receives
24 the increased capitation payment. Payments made under this
25 subsection may 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 to
3 hospitals under this subsection, in the event the MCO fails to
4 make such payments. The Department shall make available, on a
5 monthly basis, a report of the capitation payments that are
6 made to each MCO pursuant to this subsection, including the
7 number of enrollees for which such payment is made, the per
8 enrollee amount of the payment, and any adjustments that have
9 been made. Payments to MCOs that would be paid consistent with
10 actuarial certification and enrollment in the absence of the
11 increased capitation payments under this subsection shall not
12 be reduced as a consequence of payments made under this
13 subsection.

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

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

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

24 (305 ILCS 5/5A-12.4)
25 (Section scheduled to be repealed on July 1, 2018)

1 Sec. 5A-12.4. Hospital access improvement payments on or
2 after June 10, 2012.
3 (a) Hospital access improvement payments. To preserve and
4 improve access to hospital services, for hospital and physician
5 services rendered on or after June 10, 2012, the Illinois
6 Department shall, except for hospitals described in subsection
7 (b) of Section 5A-3, make payments to hospitals as set forth in
8 this Section. These payments shall be paid in 12 equal
9 installments on or before the 7th State business day of each
10 month, except that no payment shall be due within 100 days
11 after the later of the date of notification of federal approval
12 of the payment methodologies required under this Section or any
13 waiver required under 42 CFR 433.68, at which time the sum of
14 amounts required under this Section prior to the date of
15 notification is due and payable. Payments under this Section
16 are not due and payable, however, until (i) the methodologies
17 described in this Section are approved by the federal
18 government in an appropriate State Plan amendment and (ii) the
19 assessment imposed under subsection (b-5) of Section 5A-2 of
20 this Article is determined to be a permissible tax under Title
21 XIX of the Social Security Act. The Illinois Department shall
22 take all actions necessary to implement the payments under this
23 Section effective June 10, 2012, including but not limited to
24 providing public notice pursuant to federal requirements, the
25 filing of a State Plan amendment, and the adoption of
26 administrative rules. For State fiscal year 2013, payments

1 under this Section shall be increased by 21/365ths. The funding
2 source for these additional payments shall be from the
3 increased assessment under subsection (b-5) of Section 5A-2
4 that was received from hospital providers under Section 5A-4
5 for the portion of State fiscal year 2012 beginning June 10,
6 2012 through June 30, 2012.

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

10 (b) Magnet and perinatal hospital adjustment. In addition
11 to rates paid for inpatient hospital services, the Department
12 shall pay to each Illinois general acute care hospital that, as
13 of August 25, 2011, was recognized as a Magnet hospital by the
14 American Nurses Credentialing Center and that, as of September
15 14, 2011, was designated as a level III perinatal center
16 amounts as follows:

17 (1) For hospitals with a case mix index equal to or
18 greater than the 80th percentile of case mix indices for
19 all Illinois hospitals, $470 for each Medicaid general
20 acute care inpatient day of care provided by the hospital
21 during State fiscal year 2009.

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

25 (c) Trauma level II adjustment. In addition to rates paid
26 for inpatient hospital services, the Department shall pay to

1 each Illinois general acute care hospital that, as of July 1,
2 2011, was designated as a level II trauma center amounts as
3 follows:

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

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

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

17 (d) Dual-eligible adjustment. In addition to rates paid for
18 inpatient services, the Department shall pay each Illinois
19 general acute care hospital that had a ratio of crossover days
20 to total inpatient days for programs under Title XIX of the
21 Social Security Act administered by the Department (utilizing
22 information from 2009 paid claims) greater than 50%, and a case
23 mix index equal to or greater than the 75th percentile of case
24 mix indices for all Illinois hospitals, a rate of $400 for each
25 Medicaid inpatient day during State fiscal year 2009 including
26 crossover days.

1 (e) Medicaid volume adjustment. In addition to rates paid
2 for inpatient hospital services, the Department shall pay to
3 each Illinois general acute care hospital that provided more
4 than 10,000 Medicaid inpatient days of care in State fiscal
5 year 2009, has a Medicaid inpatient utilization rate of at
6 least 29.05% as calculated by the Department for the Rate Year
7 2011 Disproportionate Share determination, and is not eligible
8 for Medicaid Percentage Adjustment payments in rate year 2011
9 an amount equal to $135 for each Medicaid inpatient day of care
10 provided during State fiscal year 2009.

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

18 (g) Ambulatory service adjustment.

19 (1) In addition to the rates paid for outpatient
20 hospital services provided in the emergency department,
21 the Department shall pay each Illinois hospital an amount
22 equal to $105 multiplied by the hospital's outpatient
23 ambulatory procedure listing services for categories 3A,
24 3B, and 3C for State fiscal year 2009.

25 (2) In addition to the rates paid for outpatient
26 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

1 no event shall physicians at any individual hospital
2 collectively receive an annual, aggregate adjustment in
3 excess of $435,000, except that any amount that is not
4 distributed to a hospital because of the upper payment
5 limit shall be reallocated among the remaining eligible
6 hospitals that are below the upper payment limitation, on a
7 proportionate basis.
8 (i-5) For any children's hospital which did not charge for
9 its services during the base period, the Department shall use
10 data supplied by the hospital to determine payments using
11 similar methodologies for freestanding children's hospitals
12 under this Section or Section 5A-12.2.
13 (j) For purposes of this Section, a hospital that is
14 enrolled to provide Medicaid services during State fiscal year
15 2009 shall have its utilization and associated reimbursements
16 annualized prior to the payment calculations being performed
17 under this Section.
18 (k) For purposes of this Section, the terms "Medicaid
19 days", "ambulatory procedure listing services", and
20 "ambulatory procedure listing payments" do not include any
21 days, charges, or services for which Medicare or a managed care
22 organization reimbursed on a capitated basis was liable for
23 payment, except where explicitly stated otherwise in this
24 Section.
25 (l) Definitions. Unless the context requires otherwise or
26 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

1 Security Act, excluding days for individuals eligible for
2 Medicare under Title XVIII of that Act (Medicaid/Medicare
3 crossover days), as tabulated from the Department's paid claims
4 data for admissions occurring during State fiscal year 2009
5 that was adjudicated by the Department through June 30, 2010.

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

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

25 (m) The Department may adjust payments made under this
26 Section 5A-12.4 to comply with federal law or regulations

1 regarding hospital-specific payment limitations on
2 government-owned or government-operated hospitals.
3 (n) Notwithstanding any of the other provisions of this
4 Section, the Department is authorized to adopt rules that
5 change the hospital access improvement payments specified in
6 this Section, but only to the extent necessary to conform to
7 any federally approved amendment to the Title XIX State plan.
8 Any such rules shall be adopted by the Department as authorized
9 by Section 5-50 of the Illinois Administrative Procedure Act.
10 Notwithstanding any other provision of law, any changes
11 implemented as a result of this subsection (n) shall be given
12 retroactive effect so that they shall be deemed to have taken
13 effect as of the effective date of this Section.
14 (o) The Department of Healthcare and Family Services must
15 submit a State Medicaid Plan Amendment to the Centers for
16 Medicare and Medicaid Services to implement the payments under
17 this Section.
18 (p) Subject to federal approval and notwithstanding any
19 other provision of this Code, for any redesign of any payments
20 authorized under this Section, the volume data used to redesign
21 the distribution of payments shall include managed care
22 organization denial payments or settlements between hospitals
23 and managed care organizations.
24 (Source: P.A. 97-688, eff. 6-14-12; 98-104, eff. 7-22-13;
25 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^{TM} 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,

1 the Department shall develop adjusters to adjust the rate
2 of reimbursement for critical Medicaid providers or
3 services for trauma, transplantation services, perinatal
4 care, and Graduate Medical Education (GME).

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

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

19 (6) Beginning July 1, 2014 and ending on June 30, 2018,
20 in addition to the statewide-standardized amount, the
21 Department shall develop an adjustor to adjust the rate of
22 reimbursement for safety-net hospitals defined in Section
23 5-5e.1 of this Code excluding pediatric hospitals.

24 (7) Beginning July 1, 2014 and ending on June 30, 2018,
25 in addition to the statewide-standardized amount, the
26 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

1 Public Health in accordance with 42 CFR 485, Subpart F.
2 The EAPG standardized amounts are determined
3 separately for each critical access hospital such that
4 simulated EAPG payments using outpatient base period
5 paid claim data plus payments under Section 5A-12.4 of
6 this Code net of the associated tax costs are equal to
7 the estimated costs of outpatient base period claims
8 data with a rate year cost inflation factor applied.
9 (3) In addition to the statewide-standardized amounts,
10 the Department shall develop adjusters to adjust the rate
11 of reimbursement for critical Medicaid hospital outpatient
12 providers or services, including outpatient high volume or
13 safety-net hospitals.
14 (c) In consultation with the hospital community, the
15 Department is authorized to replace 89 Ill. Admin. Code 152.150
16 as published in 38 Ill. Reg. 4980 through 4986 within 12 months
17 of the effective date of this amendatory Act of the 98th
18 General Assembly. If the Department does not replace these
19 rules within 12 months of the effective date of this amendatory
20 Act of the 98th General Assembly, the rules in effect for
21 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall
22 remain in effect until modified by rule by the Department.
23 Nothing in this subsection shall be construed to mandate that
24 the Department file a replacement rule.
25 (d) Transition period. There shall be a transition period
26 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.

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

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

14 (g) Notwithstanding subsections (a) through (f) of this
15 Section and notwithstanding the changes authorized under
16 Section 5-5b.1, any updates to the system shall not result in
17 any diminishment of the overall effective rates of
18 reimbursement as of the implementation date of the new system
19 (July 1, 2014). These updates shall not preclude variations in
20 any individual component of the system or hospital rate
21 variations. Nothing in this Section shall prohibit the
22 Department from increasing the rates of reimbursement or
23 developing payments to ensure access to hospital services.
24 Nothing in this Section shall be construed to guarantee a
25 minimum amount of spending in the aggregate or per hospital as
26 spending may be impacted by factors including but not limited

1 to the number of individuals in the medical assistance program
2 and the severity of illness of the individuals.
3 (h) The Department shall have the authority to modify by
4 rulemaking any changes to the rates or methodologies in this
5 Section as required by the federal government to obtain federal
6 financial participation for expenditures made under this
7 Section.
8 (i) Except for subsections (g) and (h) of this Section, the
9 Department shall, pursuant to subsection (c) of Section 5-40 of
10 the Illinois Administrative Procedure Act, provide for
11 presentation at the June 2014 hearing of the Joint Committee on
12 Administrative Rules (JCAR) additional written notice to JCAR
13 of the following rules in order to commence the second notice
14 period for the following rules: rules published in the Illinois
15 Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559
16 (Medical Payment), 4628 (Specialized Health Care Delivery
17 Systems), 4640 (Hospital Services), 4932 (Diagnostic Related
18 Grouping (DRG) Prospective Payment System (PPS)), and 4977
19 (Hospital Reimbursement Changes), and published in the
20 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499
21 (Specialized Health Care Delivery Systems) and 6505 (Hospital
22 Services).
23 (Source: P.A. 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

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