AN ACT concerning State government.

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

Section 1. Short title. This Act may be cited as the FY2007 Budget Implementation (Human Services) Act.

Section 5. Purpose. It is the purpose of this Act to implement the Governor's FY2007 budget recommendations concerning human services.

Section 10. The Illinois Administrative Procedure Act is amended by changing Section 5-45 and adding Section 5-46.2 as follows:

(5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

Sec. 5-45. Emergency rulemaking.

(a) "Emergency" means the existence of any situation that any agency finds reasonably constitutes a threat to the public interest, safety, or welfare.

(b) If any agency finds that an emergency exists that requires adoption of a rule upon fewer days than is required by Section 5-40 and states in writing its reasons for that finding, the agency may adopt an emergency rule without prior notice or hearing upon filing a notice of emergency rulemaking with the Secretary of State under Section 5-70. The notice shall include the text of the emergency rule and shall be published in the Illinois Register. Consent orders or other court orders adopting settlements negotiated by an agency may be adopted under this Section. Subject to applicable constitutional or statutory provisions, an emergency rule becomes effective immediately upon filing under Section 5-65 or at a stated date less than 10 days thereafter. The agency's finding and a statement of the specific reasons for the finding

shall be filed with the rule. The agency shall take reasonable and appropriate measures to make emergency rules known to the persons who may be affected by them.

(c) An emergency rule may be effective for a period of not longer than 150 days, but the agency's authority to adopt an identical rule under Section 5-40 is not precluded. No emergency rule may be adopted more than once in any 24 month period, except that this limitation on the number of emergency rules that may be adopted in a 24 month period does not apply to (i) emergency rules that make additions to and deletions from the Drug Manual under Section 5-5.16 of the Illinois Public Aid Code or the generic drug formulary under Section 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act, or (iii) emergency rules adopted by the Illinois Department of Public Health under subsections (a) through (i) of Section 2 of the Department of Public Health Act when necessary to protect the public's health. Two or more emergency rules having substantially the same purpose and effect shall be deemed to be a single rule for purposes of this Section.

(d) In order to provide for the expeditious and timely implementation of the State's fiscal year 1999 budget, emergency rules to implement any provision of Public Act 90-587 or 90-588 or any other budget initiative for fiscal year 1999 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

(e) In order to provide for the expeditious and timely implementation of the State's fiscal year 2000 budget,

emergency rules to implement any provision of this amendatory Act of the 91st General Assembly or any other budget initiative for fiscal year 2000 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (e). The adoption of emergency rules authorized by this subsection (e) shall be deemed to be necessary for the public interest, safety, and welfare.

(f) In order to provide for the expeditious and timely implementation of the State's fiscal year 2001 budget, emergency rules to implement any provision of this amendatory Act of the 91st General Assembly or any other budget initiative for fiscal year 2001 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (f). The adoption of emergency rules authorized by this subsection (f) shall be deemed to be necessary for the public interest, safety, and welfare.

(g) In order to provide for the expeditious and timely implementation of the State's fiscal year 2002 budget, emergency rules to implement any provision of this amendatory Act of the 92nd General Assembly or any other budget initiative for fiscal year 2002 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (g). The adoption of emergency rules authorized by this subsection (g) shall be deemed to be necessary for the public interest, safety, and welfare.

(h) In order to provide for the expeditious and timely implementation of the State's fiscal year 2003 budget,

emergency rules to implement any provision of this amendatory Act of the 92nd General Assembly or any other budget initiative for fiscal year 2003 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (h). The adoption of emergency rules authorized by this subsection (h) shall be deemed to be necessary for the public interest, safety, and welfare.

(i) In order to provide for the expeditious and timely implementation of the State's fiscal year 2004 budget, emergency rules to implement any provision of this amendatory Act of the 93rd General Assembly or any other budget initiative for fiscal year 2004 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (i). The adoption of emergency rules authorized by this subsection (i) shall be deemed to be necessary for the public interest, safety, and welfare.

(j) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2005 budget as provided under the Fiscal Year 2005 Budget Implementation (Human Services) Act, emergency rules to implement any provision of the Fiscal Year 2005 Budget Implementation (Human Services) Act may be adopted in accordance with this Section by the agency charged with administering that provision, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (j). The Department of Public Aid may also adopt rules under this subsection (j) necessary to administer the Illinois Public Aid Code and the Children's Health Insurance Program Act. The adoption of emergency rules

authorized by this subsection (j) shall be deemed to be necessary for the public interest, safety, and welfare.

(k) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2006 budget, emergency rules to implement any provision of this amendatory Act of the 94th General Assembly or any other budget initiative for fiscal year 2006 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (k). The Department of Healthcare and Family Services ~~Public Aid~~ may also adopt rules under this subsection (k) necessary to administer the Illinois Public Aid Code, the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act, the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act, and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (k) shall be deemed to be necessary for the public interest, safety, and welfare.

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2007 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2007, including rules effective July 1, 2007, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (l) shall be deemed to be necessary for the public interest, safety, and welfare.

(Source: P.A. 93-20, eff. 6-20-03; 93-829, eff. 7-28-04; 93-841, eff. 7-30-04; 94-48, eff. 7-1-05; revised 12-5-05.)

(5 ILCS 100/5-46.2 new)

Sec. 5-46.2. Implementation of changes to State Medicaid plan. In order to provide for the timely and expeditious implementation of the federally approved amendment to the Title XIX State Plan as authorized by subsection (r-5) of Section 5A-12.1 of the Illinois Public Aid Code, the Department of Healthcare and Family Services may adopt any rules necessary to implement changes resulting from that amendment to the hospital access improvement payments authorized by Public Act 94-242 and subsection (d) of Section 5A-2 of the Illinois Public Aid Code. The Department is authorized to adopt rules implementing those changes by emergency rulemaking. This emergency rulemaking authority is granted by, and may be exercised only during, the 94th General Assembly.

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-5.4, 5A-2, and 5A-12.1 and adding Section 12-4.36 as follows:

(305 ILCS 5/5-5.4) (from Ch. 23, par. 5-5.4)

Sec. 5-5.4. Standards of Payment - Department of Healthcare and Family Services ~~Public Aid~~. The Department of Healthcare and Family Services ~~Public Aid~~ shall develop standards of payment of skilled nursing and intermediate care services in facilities providing such services under this Article which:

(1) Provide for the determination of a facility's payment for skilled nursing and intermediate care services on a prospective basis. The amount of the payment rate for all nursing facilities certified by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities, Long Term Care for Under Age 22 facilities, Skilled Nursing facilities, or Intermediate Care facilities under the medical assistance program shall be prospectively established annually on the basis of historical, financial, and statistical data reflecting actual costs from

prior years, which shall be applied to the current rate year and updated for inflation, except that the capital cost element for newly constructed facilities shall be based upon projected budgets. The annually established payment rate shall take effect on July 1 in 1984 and subsequent years. No rate increase and no update for inflation shall be provided on or after July 1, 1994 and before July 1, 2007 ~~2006~~, unless specifically provided for in this Section. The changes made by Public Act 93-841 ~~this amendatory Act of the 93rd General Assembly~~ extending the duration of the prohibition against a rate increase or update for inflation are effective retroactive to July 1, 2004.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1998 shall include an increase of 3%. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1998 shall include an increase of 3% plus $1.10 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care Facilities for the Developmentally Disabled or Long Term Care for Under Age 22 facilities, the rates taking effect on January 1, 2006 shall include an increase of 3%.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% plus $3.00 per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 1999 shall include an increase of 1.6% and, for services provided on or after October

1, 1999, shall be increased by $4.00 per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department. For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Skilled Nursing facilities or Intermediate Care facilities, the rates taking effect on July 1, 2000 shall include an increase of 2.5% per resident-day, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, a new payment methodology must be implemented for the nursing component of the rate effective July 1, 2003. The Department of Public Aid (now Healthcare and Family Services) shall develop the new payment methodology using the Minimum Data Set (MDS) as the instrument to collect information concerning nursing home resident condition necessary to compute the rate. The Department ~~of Public Aid~~ shall develop the new payment methodology to meet the unique needs of Illinois nursing home residents while remaining subject to the appropriations provided by the General Assembly. A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect on July 1, 2003 shall be provided for a period not exceeding 3 years after implementation of the new payment methodology as follows:

(A) For a facility that would receive a lower nursing component rate per patient day under the new system than the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be held at the level in effect on the date immediately preceding the date that the Department implements the new payment methodology until a

higher nursing component rate of reimbursement is achieved by that facility.

(B) For a facility that would receive a higher nursing component rate per patient day under the payment methodology in effect on July 1, 2003 than the facility received effective on the date immediately preceding the date that the Department implements the new payment methodology, the nursing component rate per patient day for the facility shall be adjusted.

(C) Notwithstanding paragraphs (A) and (B), the nursing component rate per patient day for the facility shall be adjusted subject to appropriations provided by the General Assembly.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on March 1, 2001 shall include a statewide increase of 7.85%, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or Long Term Care for Under Age 22 facilities, the rates taking effect on April 1, 2002 shall include a statewide increase of 2.0%, as defined by the Department. This increase terminates on July 1, 2002; beginning July 1, 2002 these rates are reduced to the level of the rates in effect on March 31, 2002, as defined by the Department.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on July 1, 2001 shall be computed using the most recent cost reports on file with the Department of Public Aid no later than April 1, 2000, updated for inflation to January 1, 2001. For rates effective July 1, 2001 only, rates shall be the greater of the rate computed for July 1, 2001 or the rate effective on June 30, 2001.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the Illinois Department shall determine by rule the rates taking effect on July 1, 2002, which shall be 5.9% less than the rates in effect on June 30, 2002.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, if the payment methodologies required under Section 5A-12 and the waiver granted under 42 CFR 433.68 are approved by the United States Centers for Medicare and Medicaid Services, the rates taking effect on July 1, 2004 shall be 3.0% greater than the rates in effect on June 30, 2004. These rates shall take effect only upon approval and implementation of the payment methodologies required under Section 5A-12.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the rates taking effect on January 1, 2005 shall be 3% more than the rates in effect on December 31, 2004.

Notwithstanding any other provisions of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as intermediate care facilities that are federally defined as Institutions for Mental Disease, a socio-development component rate equal to 6.6% of the facility's nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. The Illinois Department may by rule adjust these socio-development component rates, but in no case may such rates be diminished.

For facilities licensed by the Department of Public Health under the Nursing Home Care Act as Intermediate Care for the Developmentally Disabled facilities or as long-term care

facilities for residents under 22 years of age, the rates taking effect on July 1, 2003 shall include a statewide increase of 4%, as defined by the Department.

Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, effective January 1, 2005, facility rates shall be increased by the difference between (i) a facility's per diem property, liability, and malpractice insurance costs as reported in the cost report filed with the Department of Public Aid and used to establish rates effective July 1, 2001 and (ii) those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations, except for adjustments required under normal auditing procedures.

Rates established effective each July 1 shall govern payment for services rendered throughout that fiscal year, except that rates established on July 1, 1996 shall be increased by 6.8% for services provided on or after January 1, 1997. Such rates will be based upon the rates calculated for the year beginning July 1, 1990, and for subsequent years thereafter until June 30, 2001 shall be based on the facility cost reports for the facility fiscal year ending at any point in time during the previous calendar year, updated to the midpoint of the rate year. The cost report shall be on file with the Department no later than April 1 of the current rate year. Should the cost report not be on file by April 1, the Department shall base the rate on the latest cost report filed by each skilled care facility and intermediate care facility, updated to the midpoint of the current rate year. In determining rates for services rendered on and after July 1, 1985, fixed time shall not be computed at less than zero. The Department shall not make any alterations of regulations which would reduce any component of the Medicaid rate to a level below what that component would have been utilizing in the rate effective on July 1, 1984.

(2) Shall take into account the actual costs incurred by facilities in providing services for recipients of skilled nursing and intermediate care services under the medical assistance program.

(3) Shall take into account the medical and psycho-social characteristics and needs of the patients.

(4) Shall take into account the actual costs incurred by facilities in meeting licensing and certification standards imposed and prescribed by the State of Illinois, any of its political subdivisions or municipalities and by the U.S. Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

The Department of Healthcare and Family Services ~~Public Aid~~ shall develop precise standards for payments to reimburse nursing facilities for any utilization of appropriate rehabilitative personnel for the provision of rehabilitative services which is authorized by federal regulations, including reimbursement for services provided by qualified therapists or qualified assistants, and which is in accordance with accepted professional practices. Reimbursement also may be made for utilization of other supportive personnel under appropriate supervision.

(Source: P.A. 93-20, eff. 6-20-03; 93-649, eff. 1-8-04; 93-659, eff. 2-3-04; 93-841, eff. 7-30-04; 93-1087, eff. 2-28-05; 94-48, eff. 7-1-05; 94-85, eff. 6-28-05; 94-697, eff. 11-21-05; revised 12-15-05.)

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

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

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

(a) Subject to Sections 5A-3 and 5A-10, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to the hospital's occupied bed days multiplied by $84.19 multiplied by the proration factor for State fiscal year 2004 and the hospital's occupied bed days multiplied by $84.19 for State fiscal year 2005.

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

Subject to Sections 5A-3 and 5A-10, for the privilege of engaging in the occupation of hospital provider, beginning August 1, 2005, an annual assessment is imposed on each hospital provider for State fiscal years 2006, 2007, and 2008, in an amount equal to 2.5835% of the hospital provider's adjusted gross hospital revenue for inpatient services and 2.5835% of the hospital provider's adjusted gross hospital revenue for outpatient services. If the hospital provider's adjusted gross hospital revenue is not available, then the Illinois Department may obtain the hospital provider's adjusted gross hospital revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

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

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

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

(Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04; 93-1066, eff. 1-15-05; 94-242, eff. 7-18-05; revised 12-15-05.)

(305 ILCS 5/5A-12.1)

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

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after August 1, 2005, the Department of Public Aid shall make payments to hospitals as set forth in this Section, except for hospitals described in subsection (b) of Section 5A-3. These payments shall be paid on a quarterly basis. For State fiscal year 2006, once the approval of the payment methodology required under this Section and any waiver required under 42 CFR 433.68 by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services is received, the Department shall pay the total amounts required for fiscal year 2006 under this Section within 100 days of the latest notification. In State fiscal years 2007 and 2008, the total amounts required under this Section shall be paid in 4 equal installments on or before the seventh State business day of September, December, March, and May, except that if the date of notification of the approval of the payment methodologies required under this Section and any waiver required under 42 CFR 433.68 is on or after July 1, 2006, the sum of amounts required under this Section prior to the date of notification shall be paid within 100 days of the date of the last notification. Payments under this Section are not due and payable, however, until (i) the methodologies

described in this Section are approved by the federal government in an appropriate State Plan amendment, (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act, and (iii) the assessment is in effect.

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

(c) Medicaid high volume adjustment.

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

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

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

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

each Medicaid inpatient day of care provided during that period; and

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

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

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

(d) Intensive care adjustment. In addition to rates paid for inpatient services, the Department shall pay an adjustment payment to each Illinois general acute care hospital located in a large urban area that, based on the hospital's fiscal year 2002 Medicaid cost report, had a ratio of Medicaid intensive care unit days to total Medicaid days greater than 19%. If such ratio for the hospital is less than 30%, the hospital shall be paid an adjustment payment for each Medicaid inpatient day of care provided equal to $1,000 multiplied by the hospital's ratio of Medicaid intensive care days to total Medicaid days. If such ratio for the hospital is equal to or greater than 30%, the hospital shall be paid an adjustment payment for each Medicaid inpatient day of care provided equal to $2,800 multiplied by the hospital's ratio of Medicaid intensive care days to total Medicaid days.

(e) Trauma center adjustments.

(1) In addition to rates paid for inpatient hospital

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

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

(3) In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that as of January 1, 2005, was designated as a Level II trauma center, is located in a large urban area outside of a county with a population in excess of 3,000,000 people, and as of January 1, 2005, was designated a Level III perinatal center or designated a Level II or II+ prenatal center that

has a ratio of Medicaid intensive care unit days to total Medicaid days greater than 5%. The payment shall equal $4,000 per day for the first 500 Medicaid inpatient days, $2,000 per day for the Medicaid inpatient days between 501 and 1,500, and $100 per day for any Medicaid inpatient day in excess of 1,500. This payment shall be calculated based on data from the hospital's 2002 cost report on file with the Department on July 1, 2004.

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

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

(f) Psychiatric rate adjustment.

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

amount be less than zero.

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

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

(g) Rehabilitation adjustment.

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

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

(h) Supplemental tertiary care adjustment. In addition to rates paid for inpatient services, the Department shall pay to each Illinois hospital eligible for tertiary care adjustment payments under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2005, a supplemental tertiary care adjustment payment equal to 2.5 multiplied by the tertiary care adjustment payment required under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2005.

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

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

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

(3) for hospitals located in a large urban area whose ratio of crossover days to total Medicaid days is equal to

or greater than 55%, $1,400 per Medicaid inpatient day (including crossover days).

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

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

(k) Obstetrical care adjustments.

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

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

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

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

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

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

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

(m) Outpatient utilization payment.

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

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

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

(o) Rehabilitation hospital adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding rehabilitation hospital that does not qualify for a Medicaid percentage adjustment under 89 Ill. Adm. Code 148.122 as of October 1, 2004, an amount equal to 3 multiplied by the hospital's outpatient ambulatory procedure listing payments for Group 6A services provided during State fiscal year 2003.

(p) Perinatal outpatient adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay an adjustment payment to each large urban general acute care hospital that is designated as a perinatal center as

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

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

(r) Outpatient community access adjustment. In addition to the rates paid for outpatient hospital services, the Department shall pay an adjustment payment to each general acute care hospital that is designated as a perinatal center as of January 1, 2005, that had a Medicaid obstetrical percentage used for the October 1, 2004, Medicaid percentage adjustment determination described in 89 Ill. Adm. Code 148.122 of at least 12.5%, that had a ratio of crossover days to total Medicaid days utilizing information used for the Medicaid percentage adjustment described in 89 Ill. Adm. Code 148.122 determination effective October 1, 2004, of greater than or equal to 25%, and that qualified for the Medicaid percentage adjustment payments under 89 Ill. Adm. Code 148.122 on October

1, 2004, an amount equal to $100 multiplied by the hospital's outpatient ambulatory procedure listing services provided during State fiscal year 2003.

(r-5) Notwithstanding any of the other provisions of this Section, the Department is authorized, during this 94th General Assembly, to adopt rules that change the hospital access improvement payments specified in this Section, but only to the extent necessary to conform to any federally approved amendment to the Title XIX State plan. Any such rules shall be adopted by the Department, as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act. Notwithstanding any other provision of law, any changes implemented in relation to Public Act 94-242 shall be given retroactive effect so that they shall be deemed to have taken effect as of the effective date of that Public Act.

(s) Definitions. Unless the context requires otherwise or unless provided otherwise in this Section, the terms used in this Section for qualifying criteria and payment calculations shall have the same meanings as those terms have been given in the Illinois Department's administrative rules as in effect on May 1, 2005. Other terms shall be defined by the Illinois Department by rule.

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

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

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

"Medicaid intensive care unit days" means the number of hospital inpatient days during which Medicaid recipients

received intensive care services from the hospital, as determined from the hospital's 2002 Medicaid cost report that was on file with the Department as of July 1, 2004.

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

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

(u) For purposes of this Section, the terms "Medicaid days", "ambulatory procedure listing services", and "ambulatory procedure listing payments" do not include any days, charges, or services for which Medicare was liable for payment, except where explicitly stated otherwise in this Section.

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

(Source: P.A. 94-242, eff. 7-18-05.)

(305 ILCS 5/12-4.36 new)

Sec. 12-4.36. Pilot program for persons who are medically fragile and technology-dependent.

(a) Subject to appropriations for the first fiscal year of the pilot program beginning July 1, 2006, the Department of Human Services, in cooperation with the Department of Healthcare and Family Services, shall adopt rules to initiate a 3-year pilot program to (i) test a standardized assessment tool for persons who are medically fragile and technology-dependent who may be provided home and community-based services to meet their medical needs rather than be provided care in an institution not solely because of a severe mental or developmental impairment and (ii) provide appropriate home and

community-based medical services for such persons as provided in subsection (c) of this Section. The Department of Human Services may administer the pilot program until June 30, 2009 if the General Assembly annually appropriates funds for this purpose.

(b) Notwithstanding any other provisions of this Code, the rules implementing the pilot program shall provide for criteria, standards, procedures, and reimbursement for services that are not otherwise being provided in scope, duration, or amount through any other program administered by any Department of Human Services or any other agency of the State for these medically fragile, technology-dependent persons. At a minimum, the rules shall include the following:

(1) A requirement that a pilot program participant be eligible for medical assistance under this Code, a citizen of the United States, or an individual who is lawfully residing permanently in the United States, and a resident of Illinois.

(2) A requirement that a standardized assessment for medically fragile, technology-dependent persons will establish the level of care and the service-cost maximums.

(3) A requirement for a determination by a physician licensed to practice medicine in all its branches (i) that, except for the provision of home and community-based care, these individuals would require the level of care provided in an institutional setting and (ii) that the necessary level of care can be provided safely in the home and community through the provision of medical support services.

(4) A requirement that the services provided be medically necessary and appropriate for the level of functioning of the persons who are participating in the pilot program.

(5) Provisions for care coordination and family support services that will enable the person to receive services in the most integrated setting possible

appropriate to his or her medical condition and level of functioning.

(6) The frequency of assessment and plan-of-care reviews.

(7) The family or guardian's active participation as care givers in meeting the individual's medical needs.

(8) The estimated cost to the State for in-home care, as compared to the institutional level of care appropriate to the individual's medical needs, may not exceed 100% of the institutional care as indicated by the standardized assessment tool.

(9) When determining the hours of medically necessary support services needed to maintain the individual at home, consideration shall be given to the availability of other services, including direct care provided by the individual's family or guardian that can reasonably be expected to meet the medical needs of the individual.

(c) During the pilot program, an individual who has received services pursuant to paragraph 7 of Section 5-2 of this Code, but who no longer receive such services because he or she has reached the age of 21, may be provided additional services pursuant to rule if the Department of Human Services, Division of Rehabilitation Services, determines from completion of the assessment tool for that individual that the exceptional care rate established by the Department of Healthcare and Family Services under Section 5-5.8a of this Code is not sufficient to cover the medical needs of the individual under the home and community-based services (HCBS) waivers for persons with disabilities.

(d) The Department of Human Services is authorized to lower the payment levels established under this Section or take such other actions, including, without limitation, cessation of enrollment, reduction of available medical services, and changing standards for eligibility, that are deemed necessary by the Department during a State fiscal year to ensure that payments under this Section do not exceed available funds.

These changes may be accomplished by emergency rulemaking under Section 5-45 of the Illinois Administrative Procedure Act, except that the limitation on the number of emergency rules that may be adopted in a 24-month period shall not apply.

(e) The Department of Human Services must make an annual report to the Governor and the General Assembly with respect to the persons eligible for medical assistance under this pilot program. The report must cover the State fiscal year ending on June 30 of the preceding year. The first report is due by January 1, 2008. The report must include the following information for the fiscal year covered by the report:

(1) The number of persons who were evaluated through the assessment tool under this pilot program.

(2) The number of persons who received services not available under the home and community-based services (HCBS) waivers for persons with disabilities under this pilot program.

(3) The number of persons whose services were reduced under this pilot program.

(4) The nature, scope, and cost of services provided under this pilot program.

(5) The comparative costs of providing those services in other institutions.

(6) The Department's progress in establishing an objective, standardized assessment tool for the HCBS waiver that assesses the medical needs of medically fragile, technology-dependent adults.

(7) Recommendations for the funding needed to expand this pilot program to all medically fragile, technology-dependent individuals in HCBS waivers.

(305 ILCS 5/5-5.22 rep.)

Section 16. The Illinois Public Aid Code is amended by repealing Section 5-5.22.

Section 99. Effective date. This Act takes effect upon

becoming law.