HB1546

LRB09709366KTG49501b

97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB1546

Introduced 2/15/2011, by Rep. Lisa M. Dugan

SYNOPSIS AS INTRODUCED:

305 ILCS 5/14-8 from Ch. 23, par. 14-8

Amends the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to establish by rule methodologies for payments to hospital-based organized clinics. Sets forth certain requirements clinics must meet in order to qualify for payments, including the requirement that the clinic be adjacent to or on the premises of the hospital and be licensed under the Hospital Licensing Act or the University of Illinois Hospital Act, and the requirement that the clinic have provider-based status under the federal Medicare program. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 14-8 as follows:

(305 ILCS 5/14-8) (from Ch. 23, par. 14-8)

Sec. 14-8. Disbursements to Hospitals.

(a) For inpatient hospital services rendered on and after September 1, 1991, the Illinois Department shall reimburse hospitals for inpatient services at an inpatient payment rate calculated for each hospital based upon the Medicare Prospective Payment System as set forth in Sections 1886(b), (d), (g), and (h) of the federal Social Security Act, and the regulations, policies, and procedures promulgated thereunder, except as modified by this Section. Payment rates for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1991. Payment rates for inpatient hospital services rendered on or after October 1, 1992 and on or before March 31, 1994 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1992. Payment rates for inpatient hospital services rendered on or after April 1, 1994 shall be

calculated using the Medicare Prospective Payment rates (including the Medicare grouping methodology and weighting factors as adjusted pursuant to paragraph (1) of this subsection) in effect 90 days prior to the date of admission. For services rendered on or after July 1, 1995, the reimbursement methodology implemented under this subsection shall not include those costs referred to in Sections 1886(d)(5)(B) and 1886(h) of the Social Security Act. The additional payment amounts required under Section 1886(d)(5)(F) of the Social Security Act, for hospitals serving a disproportionate share of low-income or indigent patients, are not required under this Section. For hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated for each hospital that were in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education.

(1) The weighting factors established under Section 1886(d)(4) of the Social Security Act shall not be used in the reimbursement system established under this Section. Rather, the Illinois Department shall establish by rule Medicaid weighting factors to be used in the reimbursement system established under this Section.

(2) The Illinois Department shall define by rule those hospitals or distinct parts of hospitals that shall be

exempt from the reimbursement system established under this Section. In defining such hospitals, the Illinois Department shall take into consideration those hospitals exempt from the Medicare Prospective Payment System as of September 1, 1991. For hospitals defined as exempt under this subsection, the Illinois Department shall by rule establish a reimbursement system for payment of inpatient hospital services rendered on and after September 1, 1991. For all hospitals that are children's hospitals as defined in Section 5-5.02 of this Code, the reimbursement methodology shall, through June 30, 1992, net of all applicable fees, at least equal each children's hospital 1990 ICARE payment rates, indexed to the current year by application of the DRI hospital cost index from 1989 to the year in which payments are made. Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services) for hospital inpatient services rendered on or after July 1, 1995, the Illinois Department shall reimburse children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portion of such rates attributed

by the Illinois Department to the cost of medical education. For inpatient hospital services provided on or after August 1, 1998, the Illinois Department may establish by rule a means of adjusting the rates of children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), that did not meet that definition on June 30, 1995, in order for the inpatient hospital rates of such hospitals to take into account the average inpatient hospital rates of those children's hospitals that did meet the definition of children's hospitals on June 30, 1995.

(3) (Blank)

(4) Notwithstanding any other provision of this Section, hospitals that on August 31, 1991, have a contract with the Illinois Department under Section 3-4 of the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care.

(5) In addition to any payments made under this subsection (a), the Illinois Department shall make the adjustment payments required by Section 5-5.02 of this Code; provided, that in the case of any hospital reimbursed under a per case methodology, the Illinois Department shall add an amount equal to the product of the hospital's average length of stay, less one day, multiplied by 20, for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992.

(b) (Blank)

(b-5) Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Illinois Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services), for outpatient services rendered on or after July 1, 1995 and before July 1, 1998 the Illinois Department shall reimburse children's hospitals, as defined in the Illinois Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, less that portion of such rates attributed by the Illinois Department to the outpatient indigent volume adjustment and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portions of such rates attributed by the Illinois Department to the cost of medical education and attributed by the Illinois Department to the outpatient indigent volume adjustment. For outpatient services provided on or after July 1, 1998, reimbursement rates shall be established by rule.

(c) In addition to any other payments under this Code, the Illinois Department shall develop a hospital disproportionate share reimbursement methodology that, effective July 1, 1991, through September 30, 1992, shall reimburse hospitals sufficiently to expend the fee monies described in subsection (b) of Section 14-3 of this Code and the federal matching funds received by the Illinois Department as a result of expenditures

made by the Illinois Department as required by this subsection (c) and Section 14-2 that are attributable to fee monies deposited in the Fund, less amounts applied to adjustment payments under Section 5-5.02.

(d) Critical Care Access Payments.

(1) In addition to any other payments made under this Code, the Illinois Department shall develop a reimbursement methodology that shall reimburse Critical Care Access Hospitals for the specialized services that qualify them as Critical Care Access Hospitals. No adjustment payments shall be made under this subsection on or after July 1, 1995.

(2) "Critical Care Access Hospitals" includes, but is not limited to, hospitals that meet at least one of the following criteria:

(A) Hospitals located outside of a metropolitan statistical area that are designated as Level II Perinatal Centers and that provide a disproportionate share of perinatal services to recipients; or

(B) Hospitals that are designated as Level I Trauma Centers (adult or pediatric) and certain Level II Trauma Centers as determined by the Illinois Department; or

(C) Hospitals located outside of a metropolitan statistical area and that provide a disproportionate share of obstetrical services to recipients.

(e) Inpatient high volume adjustment. For hospital inpatient services, effective with rate periods beginning on or after October 1, 1993, in addition to rates paid for inpatient services by the Illinois Department, the Illinois Department shall make adjustment payments for inpatient services furnished by Medicaid high volume hospitals. The Illinois Department shall establish by rule criteria for qualifying as a Medicaid high volume hospital and shall establish by rule a reimbursement methodology for calculating these adjustment payments to Medicaid high volume hospitals. No adjustment payment shall be made under this subsection for services rendered on or after July 1, 1995.

(f) The Illinois Department shall modify its current rules governing adjustment payments for targeted access, critical care access, and uncompensated care to classify those adjustment payments as not being payments to disproportionate share hospitals under Title XIX of the federal Social Security Act. Rules adopted under this subsection shall not be effective with respect to services rendered on or after July 1, 1995. The Illinois Department has no obligation to adopt or implement any rules or make any payments under this subsection for services rendered on or after July 1, 1995.

(f-5) The State recognizes that adjustment payments to hospitals providing certain services or incurring certain costs may be necessary to assure that recipients of medical assistance have adequate access to necessary medical services.

These adjustments include payments for teaching costs and uncompensated care, trauma center payments, rehabilitation hospital payments, perinatal center payments, obstetrical care payments, targeted access payments, Medicaid high volume payments, and outpatient indigent volume payments. On or before April 1, 1995, the Illinois Department shall issue recommendations regarding (i) reimbursement mechanisms or adjustment payments to reflect these costs and services, including methods by which the payments may be calculated and the method by which the payments may be financed, and (ii) reimbursement mechanisms or adjustment payments to reflect costs and services of federally qualified health centers with respect to recipients of medical assistance.

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

(h) Payments under the disbursement methodology described in this Section are subject to approval by the federal government in an appropriate State plan amendment.

(i) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(j) Hospital Residing Long Term Care Services. In addition

to any other payments made under this Code, the Illinois Department may by rule establish criteria and develop methodologies for payments to hospitals for Hospital Residing Long Term Care Services.

(k) Critical Access Hospital outpatient payments. In addition to any other payments authorized under this Code, the Illinois Department shall reimburse critical access hospitals, as designated by the Illinois Department of Public Health in accordance with 42 CFR 485, Subpart F, for outpatient services at an amount that is no less than the cost of providing such services, based on Medicare cost principles. Payments under this subsection shall be subject to appropriation.

(l) Hospital-based organized clinics. The Illinois Department shall establish by rule methodologies for payments to hospital-based organized clinics. In addition to any hospital-based organized clinics eligible for reimbursement as of January 1, 2011, the Illinois Department shall, at a minimum, include those clinics that meet the following requirements:

(1) The clinic is adjacent to or on the premises of the hospital and is licensed under the Hospital Licensing Act or the University of Illinois Hospital Act;

(2) The clinic has provider-based status under Medicare pursuant to 42 CFR 413.65; or

(3) The clinic is clinically integrated as evidenced by the following:

(A) Professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross-reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital; and

(B) The clinic is fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic; and

(C) The clinic is held out to the public and other payers as part of the main hospital; and

(D) The clinic operates under the ownership and control of the main hospital, as evidenced by the following: the business enterprise that constitutes the clinic is 100% owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic; and

(E) The clinic is located within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.

(Source: P.A. 96-1382, eff. 1-1-11.)

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