HB5294

LRB10018354KTG33561b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB5294

by Rep. Gregory Harris

SYNOPSIS AS INTRODUCED:

30 ILCS 105/5.886 new
305 ILCS 5/5-5.4h
305 ILCS 5/5C-1 from Ch. 23, par. 5C-1
305 ILCS 5/5C-2 from Ch. 23, par. 5C-2
305 ILCS 5/5C-11 new

Amends the Illinois Public Aid Code. Provides that licensed medically complex for the developmentally disabled facilities (MC/DD) (rather than licensed long-term care facilities for persons under 22 years of age) that serve severely and chronically ill patients (rather than pediatric patients) shall have a specific reimbursement system designed to recognize the characteristics and needs of the patients they serve. Sets forth certain reimbursement rates for MC/DD facilities for date of services starting July 1, 2018. Requires MC/DD facilities to document within each resident's medical record the conditions or services using the minimum data set documentation standards and requirements to qualify for exceptional care reimbursement. Provides that the Department of Healthcare and Family Services shall be responsible for reimbursement calculations and direct payment for services. Imposes an assessment and licensing fee on MC/DD facilities. Creates the Medically Complex for the Developmentally Disabled Provider Fund for the purpose of receiving and disbursing assessment moneys, including making payments to intermediate care facilities for persons with a developmental disability that are also licensed as MC/DD facilities and making payments of any amounts which are reimbursable to the federal government. Makes other changes. Amends the State Finance Act to create the Medically Complex for the Developmentally Disabled Provider Fund. Effective immediately.

LRB100 18354 KTG 33561 b

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 1. The State Finance Act is amended by adding Section 5.886 as follows:

(30 ILCS 105/5.886 new)

Sec. 5.886. The Medically Complex for the Developmentally Disabled Provider Fund.

Section 5. The Illinois Public Aid Code is amended by changing Sections 5-5.4h, 5C-1, and 5C-2 and by adding Section 5C-11 as follows:

(305 ILCS 5/5-5.4h)

Sec. 5-5.4h. Medicaid reimbursement for medically complex for the developmentally disabled facilities licensed under the MC/DD Act ~~long term care facilities for persons under 22 years of age~~.

(a) Facilities licensed as medically complex for the developmentally disabled facilities ~~long-term care facilities for persons under 22 years of age~~ that serve severely and chronically ill ~~pediatric~~ patients shall have a specific reimbursement system designed to recognize the characteristics

and needs of the patients they serve.

(b) For dates of services starting July 1, 2013 and until a new reimbursement system is designed, medically complex for the developmentally disabled facilities ~~long-term care facilities for persons under 22 years of age~~ that meet the following criteria:

(1) serve exceptional care patients; and

(2) have 30% or more of their patients receiving ventilator care;

shall receive Medicaid reimbursement on a 30-day expedited schedule.

(c) Subject to federal approval of changes to the Title XIX State Plan, for dates of services starting July 1, 2014 through June 30, 2018 ~~and until a new reimbursement system is designed~~, medically complex for the developmentally disabled facilities ~~long term care facilities for persons under 22 years of age~~ which meet the criteria in subsection (b) of this Section shall receive a per diem rate for clinically complex residents of $304. Clinically complex residents on a ventilator shall receive a per diem rate of $669. For dates of services starting July 1, 2018, the total base reimbursement per diem rate for services provided by medically complex for the developmentally disabled facilities must be no less than $216. For dates of services starting July 1, 2018, medically complex for the developmentally disabled facilities must be reimbursed an exceptional care per diem rate, instead of the base rate, for

services to residents with complex or extensive medical needs. Exceptional care per diem rates must be paid for the conditions or services specified under subsection (f) at the following per diem rates: Tier 1 $255, Tier 2 $569, and Tier 3 $765.

(d) For ~~To qualify for the per diem rate of $669 for clinically complex~~ residents on a ventilator pursuant to subsection (c) or subsection (f), facilities shall have a policy documenting their method of routine assessment of a resident's weaning potential with interventions implemented noted in the resident's medical record.

(e) For services provided prior to July 1, 2018 and for ~~For~~ the purposes of this Section, a resident is considered clinically complex if the resident requires at least one of the following medical services:

(1) Tracheostomy care with dependence on mechanical ventilation for a minimum of 6 hours each day.

(2) Tracheostomy care requiring suctioning at least every 6 hours, room air mist or oxygen as needed, and dependence on one of the treatment procedures listed under paragraph (4) excluding the procedure listed in subparagraph (A) of paragraph (4).

(3) Total parenteral nutrition or other intravenous nutritional support and one of the treatment procedures listed under paragraph (4).

(4) The following treatment procedures apply to the conditions in paragraphs (2) and (3) of this subsection:

(A) Intermittent suctioning at least every 8 hours and room air mist or oxygen as needed.

(B) Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion.

(C) Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours.

(D) Tube feeding via nasogastric or gastrostomy tube.

(E) Other medical technologies required continuously, which in the opinion of the attending physician require the services of a professional nurse.

(f) Complex or extensive medical needs for exceptional care reimbursement. The conditions and services used for the purposes of this Section have the same meanings as ascribed to those conditions and services under the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) and specified in the most recent manual. Instead of submitting minimum data set assessments to the Department, medically complex for the developmentally disabled facilities must document within each resident's medical record the conditions or services using the minimum data set documentation standards and requirements to

qualify for exceptional care reimbursement.

(1) Tier 1 reimbursement is for residents who are receiving at least 51% of their caloric intake via a feeding tube and who are receiving either respiratory therapy or oxygen therapy.

(2) Tier 2 reimbursement is for residents who are receiving tracheostomy care without a ventilator and who are receiving:

(A) dialysis;

(B) suctioning; or

(C) at least 51% of their caloric intake via a feeding tube.

(3) Tier 3 reimbursement is for residents who are receiving tracheostomy care and ventilator care.

(q) For dates of services starting July 1, 2018, reimbursement calculations and direct payment for services provided by medically complex for the developmentally disabled facilities are the responsibility of the Department instead of the Department of Human Services. Appropriations for medically complex for the developmentally disabled facilities must be shifted from the Department of Human Services to the Department. Nothing in this Section prohibits the Department from paying more than the rates specified in this Section. The rates in this Section must be interpreted as a minimum amount. Any reimbursement increases applied to providers licensed under the ID/DD Community Care Act must also be applied in an

equivalent manner to medically complex for the developmentally disabled facilities.

(Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14.)

(305 ILCS 5/5C-1) (from Ch. 23, par. 5C-1)

Sec. 5C-1. Definitions. As used in this Article, unless the context requires otherwise:

"Fund" means the Care Provider Fund for Persons with a Developmental Disability.

"Care facility for persons with a developmental disability" means an intermediate care facility for the intellectually disabled within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

"Care provider for persons with a developmental disability" means a person conducting, operating, or maintaining a facility for persons with a developmental disability. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.

"Adjusted gross developmentally disabled care revenue" shall be computed separately for each facility for persons with

a developmental disability conducted, operated, or maintained by a care provider for persons with a developmental disability, and means the total revenue of the care provider for persons with a developmental disability for inpatient residential services less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, and rental of facility space.

"Long-term care facility for persons under 22 years of age serving clinically complex residents" means a facility licensed by the Department of Public Health as a long-term care facility for persons under 22 meeting the qualifications of Section 5-5.4h of this Code.

"Medically complex for the developmentally disabled facility" means a facility licensed by the Department of Public Health under the MC/DD Act.

(Source: P.A. 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 99-143, eff. 7-27-15.)

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

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

(a) For the privilege of engaging in the occupation of care provider for persons with a developmental disability, an assessment is imposed upon each care provider for persons with a developmental disability in an amount equal to 6%, or the

maximum allowed under federal regulation, whichever is less, of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but may not be added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-state medical care program, except those individuals receiving Medicare Part B benefits solely.

(b) Nothing in this amendatory Act of 1995 shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon a care provider for persons with a developmental disability or the occupation of care provider for persons with a developmental disability, or a tax or assessment measured by the income or earnings of a care provider for persons with a developmental disability.

(c) Effective July 1, 2013, for the privilege of engaging in the occupation of long-term care facility for persons under 22 years of age serving clinically complex residents provider, an assessment is imposed upon each long-term care facility for persons under 22 years of age serving clinically complex residents provider in the same amount and upon the same conditions and requirements as imposed in Article V-B of this Code and a license fee is imposed in the same amount and upon the same conditions and requirements as imposed in Article V-E

of this Code. Notwithstanding any provision of any other Act to the contrary, the assessment and license fee imposed by this subsection (c) shall be construed as a tax, but may not be added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-State medical care program, except for those individuals receiving Medicare Part B benefits solely.

(d) Beginning July 1, 2018, for the privilege of engaging in the occupation of a medically complex for the developmentally disabled facility, an assessment is imposed upon each medically complex for the developmentally disabled facility in the same amount and upon the same conditions and requirements as imposed in Article V-B of this Code and a license fee is imposed in the same amount and upon the same conditions and requirements as imposed in Article V-E of this Code. Notwithstanding any provision of any other Act to the contrary, the assessment and license fee imposed by this subsection (d) shall be construed as a tax, but may not be added to the charges of an individual's care that is paid for in whole, or in part, by a federal, State, or combined federal-State medical care program, except for those individuals receiving Medicare Part B benefits solely. The assessment and license fee collected under this subsection (d) must be deposited in the Medically Complex for the Developmentally Disabled Provider Fund.

(Source: P.A. 98-651, eff. 6-16-14; 99-143, eff. 7-27-15.)

(305 ILCS 5/5C-11 new)

Sec. 5C-11. Medically Complex for the Developmentally Disabled Provider Fund.

(a) The Medically Complex for the Developmentally Disabled Provider Fund is created as a special fund in the State treasury. All interest earned on moneys in the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medical Assistance Program by the General Assembly.

(b) The Fund is created for the purpose of receiving and disbursing assessment moneys in accordance with this Article. Disbursements from the Fund shall be made only as follows:

(1) For payments to intermediate care facilities for persons with a developmental disability under Title XIX of the Social Security Act that are also licensed by the Department of Public Health as a medically complex for the developmentally disabled facility under the MC/DD Act.

(2) For the reimbursement of moneys collected by the Department through error or mistake.

(3) For payment of administrative expenses incurred by the Department or its agent in performing the activities authorized by subsection (d) of Section 5C-2.

(4) For payments of any amounts which are reimbursable to the federal government for payments from the Fund which are required to be paid by State warrant. Disbursements

from the Fund shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Department from the assessment imposed on medically complex for the developmentally disabled facilities under subsection (d) of Section 5C-2.

(2) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to moneys deposited in the Fund.

(3) Any interest or penalty levied in conjunction with the administration of subsection (d) of Section 5C-2.

(4) All other moneys received for the Fund from any other source, including interest earned thereon.

Section 90. Implementation mandate. The Department of Healthcare and Family Services may adopt rules as allowed by the Illinois Administrative Procedure Act to implement this Act; however, the requirements of this Act must be implemented by the Department of Healthcare and Family Services even if the Department of Healthcare and Family Services has not adopted rules by the implementation date of July 1, 2018.

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