

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 Administrative Procedure Act is
5 amended by adding Section 5-45.1 as follows:

6 (5 ILCS 100/5-45.1 new)

7 Sec. 5-45.1. Emergency rulemaking. To provide for the
8 expeditious and timely implementation of changes made to
9 Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code by
10 this amendatory Act of the 101st General Assembly, emergency
11 rules may be adopted in accordance with Section 5-45 by the
12 respective Department. The 24-month limitation on the adoption
13 of emergency rules does not apply to rules adopted under this
14 Section. The adoption of emergency rules authorized by Section
15 5-45 and this Section is deemed to be necessary for the public
16 interest, safety, and welfare.

17 This Section is repealed on January 1, 2026.

18 (5 ILCS 100/5-46.3 rep.)

19 Section 10. The Illinois Administrative Procedure Act is
20 amended by repealing Section 5-46.3.

21 Section 15. The Illinois Health Facilities Planning Act is

1 amended by changing Sections 3 and 8.7 as follows:

2 (20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

3 (Section scheduled to be repealed on December 31, 2029)

4 Sec. 3. Definitions. As used in this Act:

5 "Health care facilities" means and includes the following
6 facilities, organizations, and related persons:

7 (1) An ambulatory surgical treatment center required
8 to be licensed pursuant to the Ambulatory Surgical
9 Treatment Center Act.

10 (2) An institution, place, building, or agency
11 required to be licensed pursuant to the Hospital Licensing
12 Act.

13 (3) Skilled and intermediate long term care facilities
14 licensed under the Nursing Home Care Act.

15 (A) If a demonstration project under the Nursing
16 Home Care Act applies for a certificate of need to
17 convert to a nursing facility, it shall meet the
18 licensure and certificate of need requirements in
19 effect as of the date of application.

20 (B) Except as provided in item (A) of this
21 subsection, this Act does not apply to facilities
22 granted waivers under Section 3-102.2 of the Nursing
23 Home Care Act.

24 (3.5) Skilled and intermediate care facilities
25 licensed under the ID/DD Community Care Act or the MC/DD

1 Act. No permit or exemption is required for a facility
2 licensed under the ID/DD Community Care Act or the MC/DD
3 Act prior to the reduction of the number of beds at a
4 facility. If there is a total reduction of beds at a
5 facility licensed under the ID/DD Community Care Act or the
6 MC/DD Act, this is a discontinuation or closure of the
7 facility. If a facility licensed under the ID/DD Community
8 Care Act or the MC/DD Act reduces the number of beds or
9 discontinues the facility, that facility must notify the
10 Board as provided in Section 14.1 of this Act.

11 (3.7) Facilities licensed under the Specialized Mental
12 Health Rehabilitation Act of 2013.

13 (4) Hospitals, nursing homes, ambulatory surgical
14 treatment centers, or kidney disease treatment centers
15 maintained by the State or any department or agency
16 thereof.

17 (5) Kidney disease treatment centers, including a
18 free-standing hemodialysis unit required to meet the
19 requirements of 42 CFR 494 in order to be certified for
20 participation in Medicare and Medicaid under Titles XVIII
21 and XIX of the federal Social Security Act.

22 (A) This Act does not apply to a dialysis facility
23 that provides only dialysis training, support, and
24 related services to individuals with end stage renal
25 disease who have elected to receive home dialysis.

26 (B) This Act does not apply to a dialysis unit

1 located in a licensed nursing home that offers or
2 provides dialysis-related services to residents with
3 end stage renal disease who have elected to receive
4 home dialysis within the nursing home.

5 (C) The Board, however, may require dialysis
6 facilities and licensed nursing homes under items (A)
7 and (B) of this subsection to report statistical
8 information on a quarterly basis to the Board to be
9 used by the Board to conduct analyses on the need for
10 proposed kidney disease treatment centers.

11 (6) An institution, place, building, or room used for
12 the performance of outpatient surgical procedures that is
13 leased, owned, or operated by or on behalf of an
14 out-of-state facility.

15 (7) An institution, place, building, or room used for
16 provision of a health care category of service, including,
17 but not limited to, cardiac catheterization and open heart
18 surgery.

19 (8) An institution, place, building, or room housing
20 major medical equipment used in the direct clinical
21 diagnosis or treatment of patients, and whose project cost
22 is in excess of the capital expenditure minimum.

23 "Health care facilities" does not include the following
24 entities or facility transactions:

25 (1) Federally-owned facilities.

26 (2) Facilities used solely for healing by prayer or

1 spiritual means.

2 (3) An existing facility located on any campus facility
3 as defined in Section 5-5.8b of the Illinois Public Aid
4 Code, provided that the campus facility encompasses 30 or
5 more contiguous acres and that the new or renovated
6 facility is intended for use by a licensed residential
7 facility.

8 (4) Facilities licensed under the Supportive
9 Residences Licensing Act or the Assisted Living and Shared
10 Housing Act.

11 (5) Facilities designated as supportive living
12 facilities that are in good standing with the program
13 established under Section 5-5.01a of the Illinois Public
14 Aid Code.

15 (6) Facilities established and operating under the
16 Alternative Health Care Delivery Act as a children's
17 community-based health care center alternative health care
18 model demonstration program or as an Alzheimer's Disease
19 Management Center alternative health care model
20 demonstration program.

21 (7) The closure of an entity or a portion of an entity
22 licensed under the Nursing Home Care Act, the Specialized
23 Mental Health Rehabilitation Act of 2013, the ID/DD
24 Community Care Act, or the MC/DD Act, with the exception of
25 facilities operated by a county or Illinois Veterans Homes,
26 that elect to convert, in whole or in part, to an assisted

1 living or shared housing establishment licensed under the
2 Assisted Living and Shared Housing Act and with the
3 exception of a facility licensed under the Specialized
4 Mental Health Rehabilitation Act of 2013 in connection with
5 a proposal to close a facility and re-establish the
6 facility in another location.

7 (8) Any change of ownership of a health care facility
8 that is licensed under the Nursing Home Care Act, the
9 Specialized Mental Health Rehabilitation Act of 2013, the
10 ID/DD Community Care Act, or the MC/DD Act, with the
11 exception of facilities operated by a county or Illinois
12 Veterans Homes. Changes of ownership of facilities
13 licensed under the Nursing Home Care Act must meet the
14 requirements set forth in Sections 3-101 through 3-119 of
15 the Nursing Home Care Act.

16 (9) (Blank). ~~Any project the Department of Healthcare~~
17 ~~and Family Services certifies was approved by the Hospital~~
18 ~~Transformation Review Committee as a project subject to the~~
19 ~~hospital's transformation under subsection (d 5) of~~
20 ~~Section 14-12 of the Illinois Public Aid Code, provided the~~
21 ~~hospital shall submit the certification to the Board.~~
22 ~~Nothing in this paragraph excludes a health care facility~~
23 ~~from the requirements of this Act after the approved~~
24 ~~transformation project is complete. All other requirements~~
25 ~~under this Act continue to apply. Hospitals that are not~~
26 ~~subject to this Act under this paragraph shall notify the~~

1 ~~Health Facilities and Services Review Board within 30 days~~
2 ~~of the dates that bed changes or service changes occur.~~

3 With the exception of those health care facilities
4 specifically included in this Section, nothing in this Act
5 shall be intended to include facilities operated as a part of
6 the practice of a physician or other licensed health care
7 professional, whether practicing in his individual capacity or
8 within the legal structure of any partnership, medical or
9 professional corporation, or unincorporated medical or
10 professional group. Further, this Act shall not apply to
11 physicians or other licensed health care professional's
12 practices where such practices are carried out in a portion of
13 a health care facility under contract with such health care
14 facility by a physician or by other licensed health care
15 professionals, whether practicing in his individual capacity
16 or within the legal structure of any partnership, medical or
17 professional corporation, or unincorporated medical or
18 professional groups, unless the entity constructs, modifies,
19 or establishes a health care facility as specifically defined
20 in this Section. This Act shall apply to construction or
21 modification and to establishment by such health care facility
22 of such contracted portion which is subject to facility
23 licensing requirements, irrespective of the party responsible
24 for such action or attendant financial obligation.

25 "Person" means any one or more natural persons, legal
26 entities, governmental bodies other than federal, or any

1 combination thereof.

2 "Consumer" means any person other than a person (a) whose
3 major occupation currently involves or whose official capacity
4 within the last 12 months has involved the providing,
5 administering or financing of any type of health care facility,
6 (b) who is engaged in health research or the teaching of
7 health, (c) who has a material financial interest in any
8 activity which involves the providing, administering or
9 financing of any type of health care facility, or (d) who is or
10 ever has been a member of the immediate family of the person
11 defined by item (a), (b), or (c).

12 "State Board" or "Board" means the Health Facilities and
13 Services Review Board.

14 "Construction or modification" means the establishment,
15 erection, building, alteration, reconstruction, modernization,
16 improvement, extension, discontinuation, change of ownership,
17 of or by a health care facility, or the purchase or acquisition
18 by or through a health care facility of equipment or service
19 for diagnostic or therapeutic purposes or for facility
20 administration or operation, or any capital expenditure made by
21 or on behalf of a health care facility which exceeds the
22 capital expenditure minimum; however, any capital expenditure
23 made by or on behalf of a health care facility for (i) the
24 construction or modification of a facility licensed under the
25 Assisted Living and Shared Housing Act or (ii) a conversion
26 project undertaken in accordance with Section 30 of the Older

1 Adult Services Act shall be excluded from any obligations under
2 this Act.

3 "Establish" means the construction of a health care
4 facility or the replacement of an existing facility on another
5 site or the initiation of a category of service.

6 "Major medical equipment" means medical equipment which is
7 used for the provision of medical and other health services and
8 which costs in excess of the capital expenditure minimum,
9 except that such term does not include medical equipment
10 acquired by or on behalf of a clinical laboratory to provide
11 clinical laboratory services if the clinical laboratory is
12 independent of a physician's office and a hospital and it has
13 been determined under Title XVIII of the Social Security Act to
14 meet the requirements of paragraphs (10) and (11) of Section
15 1861(s) of such Act. In determining whether medical equipment
16 has a value in excess of the capital expenditure minimum, the
17 value of studies, surveys, designs, plans, working drawings,
18 specifications, and other activities essential to the
19 acquisition of such equipment shall be included.

20 "Capital expenditure" means an expenditure: (A) made by or
21 on behalf of a health care facility (as such a facility is
22 defined in this Act); and (B) which under generally accepted
23 accounting principles is not properly chargeable as an expense
24 of operation and maintenance, or is made to obtain by lease or
25 comparable arrangement any facility or part thereof or any
26 equipment for a facility or part; and which exceeds the capital

1 expenditure minimum.

2 For the purpose of this paragraph, the cost of any studies,
3 surveys, designs, plans, working drawings, specifications, and
4 other activities essential to the acquisition, improvement,
5 expansion, or replacement of any plant or equipment with
6 respect to which an expenditure is made shall be included in
7 determining if such expenditure exceeds the capital
8 expenditures minimum. Unless otherwise interdependent, or
9 submitted as one project by the applicant, components of
10 construction or modification undertaken by means of a single
11 construction contract or financed through the issuance of a
12 single debt instrument shall not be grouped together as one
13 project. Donations of equipment or facilities to a health care
14 facility which if acquired directly by such facility would be
15 subject to review under this Act shall be considered capital
16 expenditures, and a transfer of equipment or facilities for
17 less than fair market value shall be considered a capital
18 expenditure for purposes of this Act if a transfer of the
19 equipment or facilities at fair market value would be subject
20 to review.

21 "Capital expenditure minimum" means \$11,500,000 for
22 projects by hospital applicants, \$6,500,000 for applicants for
23 projects related to skilled and intermediate care long-term
24 care facilities licensed under the Nursing Home Care Act, and
25 \$3,000,000 for projects by all other applicants, which shall be
26 annually adjusted to reflect the increase in construction costs

1 due to inflation, for major medical equipment and for all other
2 capital expenditures.

3 "Financial commitment" means the commitment of at least 33%
4 of total funds assigned to cover total project cost, which
5 occurs by the actual expenditure of 33% or more of the total
6 project cost or the commitment to expend 33% or more of the
7 total project cost by signed contracts or other legal means.

8 "Non-clinical service area" means an area (i) for the
9 benefit of the patients, visitors, staff, or employees of a
10 health care facility and (ii) not directly related to the
11 diagnosis, treatment, or rehabilitation of persons receiving
12 services from the health care facility. "Non-clinical service
13 areas" include, but are not limited to, chapels; gift shops;
14 news stands; computer systems; tunnels, walkways, and
15 elevators; telephone systems; projects to comply with life
16 safety codes; educational facilities; student housing;
17 patient, employee, staff, and visitor dining areas;
18 administration and volunteer offices; modernization of
19 structural components (such as roof replacement and masonry
20 work); boiler repair or replacement; vehicle maintenance and
21 storage facilities; parking facilities; mechanical systems for
22 heating, ventilation, and air conditioning; loading docks; and
23 repair or replacement of carpeting, tile, wall coverings,
24 window coverings or treatments, or furniture. Solely for the
25 purpose of this definition, "non-clinical service area" does
26 not include health and fitness centers.

1 "Areawide" means a major area of the State delineated on a
2 geographic, demographic, and functional basis for health
3 planning and for health service and having within it one or
4 more local areas for health planning and health service. The
5 term "region", as contrasted with the term "subregion", and the
6 word "area" may be used synonymously with the term "areawide".

7 "Local" means a subarea of a delineated major area that on
8 a geographic, demographic, and functional basis may be
9 considered to be part of such major area. The term "subregion"
10 may be used synonymously with the term "local".

11 "Physician" means a person licensed to practice in
12 accordance with the Medical Practice Act of 1987, as amended.

13 "Licensed health care professional" means a person
14 licensed to practice a health profession under pertinent
15 licensing statutes of the State of Illinois.

16 "Director" means the Director of the Illinois Department of
17 Public Health.

18 "Agency" or "Department" means the Illinois Department of
19 Public Health.

20 "Alternative health care model" means a facility or program
21 authorized under the Alternative Health Care Delivery Act.

22 "Out-of-state facility" means a person that is both (i)
23 licensed as a hospital or as an ambulatory surgery center under
24 the laws of another state or that qualifies as a hospital or an
25 ambulatory surgery center under regulations adopted pursuant
26 to the Social Security Act and (ii) not licensed under the

1 Ambulatory Surgical Treatment Center Act, the Hospital
2 Licensing Act, or the Nursing Home Care Act. Affiliates of
3 out-of-state facilities shall be considered out-of-state
4 facilities. Affiliates of Illinois licensed health care
5 facilities 100% owned by an Illinois licensed health care
6 facility, its parent, or Illinois physicians licensed to
7 practice medicine in all its branches shall not be considered
8 out-of-state facilities. Nothing in this definition shall be
9 construed to include an office or any part of an office of a
10 physician licensed to practice medicine in all its branches in
11 Illinois that is not required to be licensed under the
12 Ambulatory Surgical Treatment Center Act.

13 "Change of ownership of a health care facility" means a
14 change in the person who has ownership or control of a health
15 care facility's physical plant and capital assets. A change in
16 ownership is indicated by the following transactions: sale,
17 transfer, acquisition, lease, change of sponsorship, or other
18 means of transferring control.

19 "Related person" means any person that: (i) is at least 50%
20 owned, directly or indirectly, by either the health care
21 facility or a person owning, directly or indirectly, at least
22 50% of the health care facility; or (ii) owns, directly or
23 indirectly, at least 50% of the health care facility.

24 "Charity care" means care provided by a health care
25 facility for which the provider does not expect to receive
26 payment from the patient or a third-party payer.

1 "Freestanding emergency center" means a facility subject
2 to licensure under Section 32.5 of the Emergency Medical
3 Services (EMS) Systems Act.

4 "Category of service" means a grouping by generic class of
5 various types or levels of support functions, equipment, care,
6 or treatment provided to patients or residents, including, but
7 not limited to, classes such as medical-surgical, pediatrics,
8 or cardiac catheterization. A category of service may include
9 subcategories or levels of care that identify a particular
10 degree or type of care within the category of service. Nothing
11 in this definition shall be construed to include the practice
12 of a physician or other licensed health care professional while
13 functioning in an office providing for the care, diagnosis, or
14 treatment of patients. A category of service that is subject to
15 the Board's jurisdiction must be designated in rules adopted by
16 the Board.

17 "State Board Staff Report" means the document that sets
18 forth the review and findings of the State Board staff, as
19 prescribed by the State Board, regarding applications subject
20 to Board jurisdiction.

21 (Source: P.A. 100-518, eff. 6-1-18; 100-581, eff. 3-12-18;
22 100-957, eff. 8-19-18; 101-81, eff. 7-12-19.)

23 (20 ILCS 3960/8.7)

24 (Section scheduled to be repealed on December 31, 2029)

25 Sec. 8.7. Application for permit for discontinuation of a

1 health care facility or category of service; public notice and
2 public hearing.

3 (a) Upon a finding that an application to close a health
4 care facility or discontinue a category of service is complete,
5 the State Board shall publish a legal notice on 3 consecutive
6 days in a newspaper of general circulation in the area or
7 community to be affected and afford the public an opportunity
8 to request a hearing. If the application is for a facility
9 located in a Metropolitan Statistical Area, an additional legal
10 notice shall be published in a newspaper of limited
11 circulation, if one exists, in the area in which the facility
12 is located. If the newspaper of limited circulation is
13 published on a daily basis, the additional legal notice shall
14 be published on 3 consecutive days. The legal notice shall also
15 be posted on the Health Facilities and Services Review Board's
16 website and sent to the State Representative and State Senator
17 of the district in which the health care facility is located.
18 In addition, the health care facility shall provide notice of
19 closure to the local media that the health care facility would
20 routinely notify about facility events.

21 An application to close a health care facility shall only
22 be deemed complete if it includes evidence that the health care
23 facility provided written notice at least 30 days prior to
24 filing the application of its intent to do so to the
25 municipality in which it is located, the State Representative
26 and State Senator of the district in which the health care

1 facility is located, the State Board, the Director of Public
2 Health, and the Director of Healthcare and Family Services. The
3 changes made to this subsection by this amendatory Act of the
4 101st General Assembly shall apply to all applications
5 submitted after the effective date of this amendatory Act of
6 the 101st General Assembly.

7 (b) No later than 30 days after issuance of a permit to
8 close a health care facility or discontinue a category of
9 service, the permit holder shall give written notice of the
10 closure or discontinuation to the State Senator and State
11 Representative serving the legislative district in which the
12 health care facility is located.

13 (c) If there is a pending lawsuit that challenges an
14 application to discontinue a health care facility that either
15 names the Board as a party or alleges fraud in the filing of
16 the application, the Board may defer action on the application
17 for up to 6 months after the date of the initial deferral of
18 the application.

19 (d) The changes made to this Section by this amendatory Act
20 of the 101st General Assembly shall apply to all applications
21 submitted after the effective date of this amendatory Act of
22 the 101st General Assembly.

23 (Source: P.A. 101-83, eff. 7-15-19.)

24 Section 20. The State Finance Act is amended by changing
25 Section 6z-81 as follows:

1 (30 ILCS 105/6z-81)

2 Sec. 6z-81. Healthcare Provider Relief Fund.

3 (a) There is created in the State treasury a special fund
4 to be known as the Healthcare Provider Relief Fund.

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

8 (1) Subject to appropriation, for payment by the
9 Department of Healthcare and Family Services or by the
10 Department of Human Services of medical bills and related
11 expenses, including administrative expenses, for which the
12 State is responsible under Titles XIX and XXI of the Social
13 Security Act, the Illinois Public Aid Code, the Children's
14 Health Insurance Program Act, the Covering ALL KIDS Health
15 Insurance Act, and the Long Term Acute Care Hospital
16 Quality Improvement Transfer Program Act.

17 (2) For repayment of funds borrowed from other State
18 funds or from outside sources, including interest thereon.

19 (3) For ~~State fiscal years 2017, 2018, and 2019, for~~
20 making payments to the human poison control center pursuant
21 to Section 12-4.105 of the Illinois Public Aid Code.

22 (c) The Fund shall consist of the following:

23 (1) Moneys received by the State from short-term
24 borrowing pursuant to the Short Term Borrowing Act on or
25 after the effective date of Public Act 96-820.

1 (2) All federal matching funds received by the Illinois
2 Department of Healthcare and Family Services as a result of
3 expenditures made by the Department that are attributable
4 to moneys deposited in the Fund.

5 (3) All federal matching funds received by the Illinois
6 Department of Healthcare and Family Services as a result of
7 federal approval of Title XIX State plan amendment
8 transmittal number 07-09.

9 (3.5) Proceeds from the assessment authorized under
10 Article V-H of the Illinois Public Aid Code.

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

13 (5) All federal matching funds received by the Illinois
14 Department of Healthcare and Family Services as a result of
15 expenditures made by the Department for Medical Assistance
16 from the General Revenue Fund, the Tobacco Settlement
17 Recovery Fund, the Long-Term Care Provider Fund, and the
18 Drug Rebate Fund related to individuals eligible for
19 medical assistance pursuant to the Patient Protection and
20 Affordable Care Act (P.L. 111-148) and Section 5-2 of the
21 Illinois Public Aid Code.

22 (d) In addition to any other transfers that may be provided
23 for by law, on the effective date of Public Act 97-44, or as
24 soon thereafter as practical, the State Comptroller shall
25 direct and the State Treasurer shall transfer the sum of
26 \$365,000,000 from the General Revenue Fund into the Healthcare

1 Provider Relief Fund.

2 (e) In addition to any other transfers that may be provided
3 for by law, on July 1, 2011, or as soon thereafter as
4 practical, the State Comptroller shall direct and the State
5 Treasurer shall transfer the sum of \$160,000,000 from the
6 General Revenue Fund to the Healthcare Provider Relief Fund.

7 (f) Notwithstanding any other State law to the contrary,
8 and in addition to any other transfers that may be provided for
9 by law, the State Comptroller shall order transferred and the
10 State Treasurer shall transfer \$500,000,000 to the Healthcare
11 Provider Relief Fund from the General Revenue Fund in equal
12 monthly installments of \$100,000,000, with the first transfer
13 to be made on July 1, 2012, or as soon thereafter as practical,
14 and with each of the remaining transfers to be made on August
15 1, 2012, September 1, 2012, October 1, 2012, and November 1,
16 2012, or as soon thereafter as practical. This transfer may
17 assist the Department of Healthcare and Family Services in
18 improving Medical Assistance bill processing timeframes or in
19 meeting the possible requirements of Senate Bill 3397, or other
20 similar legislation, of the 97th General Assembly should it
21 become law.

22 (g) Notwithstanding any other State law to the contrary,
23 and in addition to any other transfers that may be provided for
24 by law, on July 1, 2013, or as soon thereafter as may be
25 practical, the State Comptroller shall direct and the State
26 Treasurer shall transfer the sum of \$601,000,000 from the

1 General Revenue Fund to the Healthcare Provider Relief Fund.
2 (Source: P.A. 100-587, eff. 6-4-18; 101-9, eff. 6-5-19; revised
3 7-17-19.)

4 Section 25. The Emergency Medical Services (EMS) Systems
5 Act is amended by changing Section 32.5 as follows:

6 (210 ILCS 50/32.5)

7 Sec. 32.5. Freestanding Emergency Center.

8 (a) The Department shall issue an annual Freestanding
9 Emergency Center (FEC) license to any facility that has
10 received a permit from the Health Facilities and Services
11 Review Board to establish a Freestanding Emergency Center by
12 January 1, 2015, and:

13 (1) is located: (A) in a municipality with a population
14 of 50,000 or fewer inhabitants; (B) within 50 miles of the
15 hospital that owns or controls the FEC; and (C) within 50
16 miles of the Resource Hospital affiliated with the FEC as
17 part of the EMS System;

18 (2) is wholly owned or controlled by an Associate or
19 Resource Hospital, but is not a part of the hospital's
20 physical plant;

21 (3) meets the standards for licensed FECs, adopted by
22 rule of the Department, including, but not limited to:

23 (A) facility design, specification, operation, and
24 maintenance standards;

1 (B) equipment standards; and

2 (C) the number and qualifications of emergency
3 medical personnel and other staff, which must include
4 at least one board certified emergency physician
5 present at the FEC 24 hours per day.

6 (4) limits its participation in the EMS System strictly
7 to receiving a limited number of patients by ambulance: (A)
8 according to the FEC's 24-hour capabilities; (B) according
9 to protocols developed by the Resource Hospital within the
10 FEC's designated EMS System; and (C) as pre-approved by
11 both the EMS Medical Director and the Department;

12 (5) provides comprehensive emergency treatment
13 services, as defined in the rules adopted by the Department
14 pursuant to the Hospital Licensing Act, 24 hours per day,
15 on an outpatient basis;

16 (6) provides an ambulance and maintains on site
17 ambulance services staffed with paramedics 24 hours per
18 day;

19 (7) (blank);

20 (8) complies with all State and federal patient rights
21 provisions, including, but not limited to, the Emergency
22 Medical Treatment Act and the federal Emergency Medical
23 Treatment and Active Labor Act;

24 (9) maintains a communications system that is fully
25 integrated with its Resource Hospital within the FEC's
26 designated EMS System;

1 (10) reports to the Department any patient transfers
2 from the FEC to a hospital within 48 hours of the transfer
3 plus any other data determined to be relevant by the
4 Department;

5 (11) submits to the Department, on a quarterly basis,
6 the FEC's morbidity and mortality rates for patients
7 treated at the FEC and other data determined to be relevant
8 by the Department;

9 (12) does not describe itself or hold itself out to the
10 general public as a full service hospital or hospital
11 emergency department in its advertising or marketing
12 activities;

13 (13) complies with any other rules adopted by the
14 Department under this Act that relate to FECs;

15 (14) passes the Department's site inspection for
16 compliance with the FEC requirements of this Act;

17 (15) submits a copy of the permit issued by the Health
18 Facilities and Services Review Board indicating that the
19 facility has complied with the Illinois Health Facilities
20 Planning Act with respect to the health services to be
21 provided at the facility;

22 (16) submits an application for designation as an FEC
23 in a manner and form prescribed by the Department by rule;
24 and

25 (17) pays the annual license fee as determined by the
26 Department by rule.

1 (a-5) Notwithstanding any other provision of this Section,
2 the Department may issue an annual FEC license to a facility
3 that is located in a county that does not have a licensed
4 general acute care hospital if the facility's application for a
5 permit from the Illinois Health Facilities Planning Board has
6 been deemed complete by the Department of Public Health by
7 January 1, 2014 and if the facility complies with the
8 requirements set forth in paragraphs (1) through (17) of
9 subsection (a).

10 (a-10) Notwithstanding any other provision of this
11 Section, the Department may issue an annual FEC license to a
12 facility if the facility has, by January 1, 2014, filed a
13 letter of intent to establish an FEC and if the facility
14 complies with the requirements set forth in paragraphs (1)
15 through (17) of subsection (a).

16 (a-15) Notwithstanding any other provision of this
17 Section, the Department shall issue an annual FEC license to a
18 facility if the facility: (i) discontinues operation as a
19 hospital within 180 days after December 4, 2015 (the effective
20 date of Public Act 99-490) ~~this amendatory Act of the 99th~~
21 ~~General Assembly~~ with a Health Facilities and Services Review
22 Board project number of E-017-15; (ii) has an application for a
23 permit to establish an FEC from the Health Facilities and
24 Services Review Board that is deemed complete by January 1,
25 2017; and (iii) complies with the requirements set forth in
26 paragraphs (1) through (17) of subsection (a) of this Section.

1 (a-20) Notwithstanding any other provision of this
2 Section, the Department shall issue an annual FEC license to a
3 facility if:

4 (1) the facility is a hospital that has discontinued
5 inpatient hospital services;

6 (2) the Department of Healthcare and Family Services
7 has approved ~~certified~~ the conversion to an FEC ~~was~~
8 ~~approved by the Hospital Transformation Review Committee~~
9 as a project subject to the hospital's transformation under
10 subsection (d-5) of Section 14-12 of the Illinois Public
11 Aid Code;

12 (3) the facility complies with the requirements set
13 forth in paragraphs (1) through (17), provided however that
14 the FEC may be located in a municipality with a population
15 greater than 50,000 inhabitants and shall not be subject to
16 the requirements of the Illinois Health Facilities
17 Planning Act that are applicable to the conversion to an
18 FEC if the Department of Healthcare and Family Services
19 ~~Service~~ has approved ~~certified~~ the conversion to an FEC ~~was~~
20 ~~approved by the Hospital Transformation Review Committee~~
21 as a project subject to the hospital's transformation under
22 subsection (d-5) of Section 14-12 of the Illinois Public
23 Aid Code; and

24 (4) the facility is located at the same physical
25 location where the facility served as a hospital.

26 (b) The Department shall:

1 (1) annually inspect facilities of initial FEC
2 applicants and licensed FECs, and issue annual licenses to
3 or annually relicense FECs that satisfy the Department's
4 licensure requirements as set forth in subsection (a);

5 (2) suspend, revoke, refuse to issue, or refuse to
6 renew the license of any FEC, after notice and an
7 opportunity for a hearing, when the Department finds that
8 the FEC has failed to comply with the standards and
9 requirements of the Act or rules adopted by the Department
10 under the Act;

11 (3) issue an Emergency Suspension Order for any FEC
12 when the Director or his or her designee has determined
13 that the continued operation of the FEC poses an immediate
14 and serious danger to the public health, safety, and
15 welfare. An opportunity for a hearing shall be promptly
16 initiated after an Emergency Suspension Order has been
17 issued; and

18 (4) adopt rules as needed to implement this Section.

19 (Source: P.A. 99-490, eff. 12-4-15; 99-710, eff. 8-5-16;
20 100-581, eff. 3-12-18; revised 7-23-19.)

21 Section 30. The Illinois Public Aid Code is amended by
22 changing Sections 5-5e.1, 5A-2, 5A-4, 5A-8, 5A-10, 5A-13,
23 5A-14, 12-4.105, and 14-12 and by adding Sections 5-5.05c,
24 5A-12.7, 5A-12.8, and 5A-17 as follows:

1 (305 ILCS 5/5-5.05c new)

2 Sec. 5-5.05c. Access to physician services. The Department
3 shall increase rates of reimbursement for physician services to
4 as close to 60% of Medicare rates in effect as of January 1,
5 2020 utilizing the rates of Illinois Locality 99 facility
6 rates.

7 (305 ILCS 5/5-5e.1)

8 Sec. 5-5e.1. Safety-Net Hospitals.

9 (a) A Safety-Net Hospital is an Illinois hospital that:

10 (1) is licensed by the Department of Public Health as a
11 general acute care or pediatric hospital; and

12 (2) is a disproportionate share hospital, as described
13 in Section 1923 of the federal Social Security Act, as
14 determined by the Department; and

15 (3) meets one of the following:

16 (A) has a MIUR of at least 40% and a charity
17 percent of at least 4%; or

18 (B) has a MIUR of at least 50%.

19 (b) Definitions. As used in this Section:

20 (1) "Charity percent" means the ratio of (i) the
21 hospital's charity charges for services provided to
22 individuals without health insurance or another source of
23 third party coverage to (ii) the Illinois total hospital
24 charges, each as reported on the hospital's OBRA form.

25 (2) "MIUR" means Medicaid Inpatient Utilization Rate

1 and is defined as a fraction, the numerator of which is the
2 number of a hospital's inpatient days provided in the
3 hospital's fiscal year ending 3 years prior to the rate
4 year, to patients who, for such days, were eligible for
5 Medicaid under Title XIX of the federal Social Security
6 Act, 42 USC 1396a et seq., excluding those persons eligible
7 for medical assistance pursuant to 42 U.S.C.
8 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
9 Section 5-2 of this Article, and the denominator of which
10 is the total number of the hospital's inpatient days in
11 that same period, excluding those persons eligible for
12 medical assistance pursuant to 42 U.S.C.
13 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
14 Section 5-2 of this Article.

15 (3) "OBRA form" means form HFS-3834, OBRA '93 data
16 collection form, for the rate year.

17 (4) "Rate year" means the 12-month period beginning on
18 October 1.

19 (c) Beginning July 1, 2012 and ending on December 31, 2022
20 ~~June 30, 2020~~, a hospital that would have qualified for the
21 rate year beginning October 1, 2011, shall be a Safety-Net
22 Hospital.

23 (d) No later than August 15 preceding the rate year, each
24 hospital shall submit the OBRA form to the Department. Prior to
25 October 1, the Department shall notify each hospital whether it
26 has qualified as a Safety-Net Hospital.

1 (e) The Department may promulgate rules in order to
2 implement this Section.

3 (f) Nothing in this Section shall be construed as limiting
4 the ability of the Department to include the Safety-Net
5 Hospitals in the hospital rate reform mandated by Section 14-11
6 of this Code and implemented under Section 14-12 of this Code
7 and by administrative rulemaking.

8 (Source: P.A. 100-581, eff. 3-12-18.)

9 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

10 (Section scheduled to be repealed on July 1, 2020)

11 Sec. 5A-2. Assessment.

12 (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal
13 years 2009 through 2018, or as long as continued under Section
14 5A-16, an annual assessment on inpatient services is imposed on
15 each hospital provider in an amount equal to \$218.38 multiplied
16 by the difference of the hospital's occupied bed days less the
17 hospital's Medicare bed days, provided, however, that the
18 amount of \$218.38 shall be increased by a uniform percentage to
19 generate an amount equal to 75% of the State share of the
20 payments authorized under Section 5A-12.5, with such increase
21 only taking effect upon the date that a State share for such
22 payments is required under federal law. For the period of April
23 through June 2015, the amount of \$218.38 used to calculate the
24 assessment under this paragraph shall, by emergency rule under
25 subsection (s) of Section 5-45 of the Illinois Administrative

1 Procedure Act, be increased by a uniform percentage to generate
2 \$20,250,000 in the aggregate for that period from all hospitals
3 subject to the 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, or as provided in Section 5A-16, in addition
7 to any federally required State share as authorized under
8 paragraph (1), the amount of \$218.38 shall be increased by a
9 uniform percentage to generate an amount equal to 75% of the
10 ACA Assessment Adjustment, as defined in subsection (b-6) of
11 this Section.

12 For State fiscal years 2009 through 2018, or as provided in
13 Section 5A-16, a hospital's occupied bed days and Medicare bed
14 days shall be determined using the most recent data available
15 from each hospital's 2005 Medicare cost report as contained in
16 the Healthcare Cost Report Information System file, for the
17 quarter ending on December 31, 2006, without regard to any
18 subsequent adjustments or changes to such data. If a hospital's
19 2005 Medicare cost report is not contained in the Healthcare
20 Cost Report Information System, then the Illinois Department
21 may obtain the hospital provider's occupied bed days and
22 Medicare bed days from any source available, including, but not
23 limited to, records maintained by the hospital provider, which
24 may be inspected at all times during business hours of the day
25 by the Illinois Department or its duly authorized agents and
26 employees.

1 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
2 fiscal years 2019 and 2020, an annual assessment on inpatient
3 services is imposed on each hospital provider in an amount
4 equal to \$197.19 multiplied by the difference of the hospital's
5 occupied bed days less the hospital's Medicare bed days,
6 ~~however, for State fiscal year 2021, the amount of \$197.19~~
7 ~~shall be increased by a uniform percentage to generate an~~
8 ~~additional \$6,250,000 in the aggregate for that period from all~~
9 ~~hospitals subject to the annual assessment under this~~
10 ~~paragraph.~~ For State fiscal years 2019 and 2020, a hospital's
11 occupied bed days and Medicare bed days shall be determined
12 using the most recent data available from each hospital's 2015
13 Medicare cost report as contained in the Healthcare Cost Report
14 Information System file, for the quarter ending on March 31,
15 2017, without regard to any subsequent adjustments or changes
16 to such data. If a hospital's 2015 Medicare cost report is not
17 contained in the Healthcare Cost Report Information System,
18 then the Illinois Department may obtain the hospital provider's
19 occupied bed days and Medicare bed days from any source
20 available, including, but not limited to, records maintained by
21 the hospital provider, which may be inspected at all times
22 during business hours of the day by the Illinois Department or
23 its duly authorized agents and employees. Notwithstanding any
24 other provision in this Article, for a hospital provider that
25 did not have a 2015 Medicare cost report, but paid an
26 assessment in State fiscal year 2018 on the basis of

1 hypothetical data, that assessment amount shall be used for
2 State fiscal years 2019 and 2020; ~~however, for State fiscal~~
3 ~~year 2021, the assessment amount shall be increased by the~~
4 ~~proportion that it represents of the total annual assessment~~
5 ~~that is generated from all hospitals in order to generate~~
6 ~~\$6,250,000 in the aggregate for that period from all hospitals~~
7 ~~subject to the annual assessment under this paragraph.~~

8 (4) Subject to Sections 5A-3 and 5A-10, for the period of
9 July 1, 2020 through December 31, 2020 and calendar State
10 ~~fiscal~~ years 2021 and 2022 ~~through 2024~~, an annual assessment
11 on inpatient services is imposed on each hospital provider in
12 an amount equal to \$221.50 ~~\$197.19~~ multiplied by the difference
13 of the hospital's occupied bed days less the hospital's
14 Medicare bed days, provided however: for the period of July 1,
15 2020 through December 31, 2020, (i) the assessment shall be
16 equal to 50% of the annual amount; and (ii) the amount of
17 \$221.50 shall be retroactively adjusted by a uniform percentage
18 to generate an amount equal to 50% of the Assessment
19 Adjustment, as defined in subsection (b-7), ~~that the amount of~~
20 ~~\$197.19 used to calculate the assessment under this paragraph~~
21 ~~shall, by rule, be adjusted by a uniform percentage to generate~~
22 ~~the same total annual assessment that was generated in State~~
23 ~~fiscal year 2020 from all hospitals subject to the annual~~
24 ~~assessment under this paragraph plus \$6,250,000. For the period~~
25 of July 1, 2020 through December 31, 2020 and calendar State
26 ~~fiscal~~ years 2021 and 2022, a hospital's occupied bed days and

1 Medicare bed days shall be determined using the most recent
2 data available from each hospital's 2015 ~~2017~~ Medicare cost
3 report as contained in the Healthcare Cost Report Information
4 System file, for the quarter ending on March 31, 2017 ~~2019~~,
5 without regard to any subsequent adjustments or changes to such
6 data. If a hospital's 2015 Medicare cost report is not
7 contained in the Healthcare Cost Report Information System,
8 then the Illinois Department may obtain the hospital provider's
9 occupied bed days and Medicare bed days from any source
10 available, including, but not limited to, records maintained by
11 the hospital provider, which may be inspected at all times
12 during business hours of the day by the Illinois Department or
13 its duly authorized agents and employees. Should the change in
14 the assessment methodology for fiscal years 2021 through
15 December 31, 2022 not be approved on or before June 30, 2020,
16 the assessment and payments under this Article in effect for
17 fiscal year 2020 shall remain in place until the new assessment
18 is approved. If the assessment methodology for July 1, 2020
19 through December 31, 2022, is approved on or after July 1,
20 2020, it shall be retroactive to July 1, 2020, subject to
21 federal approval and provided that the payments authorized
22 under Section 5A-12.7 have the same effective date as the new
23 assessment methodology. In giving retroactive effect to the
24 assessment approved after June 30, 2020, credit toward the new
25 assessment shall be given for any payments of the previous
26 assessment for periods after June 30, 2020. Notwithstanding any

1 other provision of this Article, for a hospital provider that
2 did not have a 2015 Medicare cost report, but paid an
3 assessment in State Fiscal Year 2020 on the basis of
4 hypothetical data, the data that was the basis for the 2020
5 assessment shall be used to calculate the assessment under this
6 paragraph. ~~For State fiscal years 2023 and 2024, a hospital's~~
7 ~~occupied bed days and Medicare bed days shall be determined~~
8 ~~using the most recent data available from each hospital's 2019~~
9 ~~Medicare cost report as contained in the Healthcare Cost Report~~
10 ~~Information System file, for the quarter ending on March 31,~~
11 ~~2021, without regard to any subsequent adjustments or changes~~
12 ~~to such data.~~

13 (b) (Blank).

14 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the
15 portion of State fiscal year 2012, beginning June 10, 2012
16 through June 30, 2012, and for State fiscal years 2013 through
17 2018, or as provided in Section 5A-16, an annual assessment on
18 outpatient services is imposed on each hospital provider in an
19 amount equal to .008766 multiplied by the hospital's outpatient
20 gross revenue, provided, however, that the amount of .008766
21 shall be increased by a uniform percentage to generate an
22 amount equal to 25% of the State share of the payments
23 authorized under Section 5A-12.5, with such increase only
24 taking effect upon the date that a State share for such
25 payments is required under federal law. For the period
26 beginning June 10, 2012 through June 30, 2012, the annual

1 assessment on outpatient services shall be prorated by
2 multiplying the assessment amount by a fraction, the numerator
3 of which is 21 days and the denominator of which is 365 days.
4 For the period of April through June 2015, the amount of
5 .008766 used to calculate the assessment under this paragraph
6 shall, by emergency rule under subsection (s) of Section 5-45
7 of the Illinois Administrative Procedure Act, be increased by a
8 uniform percentage to generate \$6,750,000 in the aggregate for
9 that period from all hospitals subject to the annual assessment
10 under this paragraph.

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

18 For the portion of State fiscal year 2012, beginning June
19 10, 2012 through June 30, 2012, and State fiscal years 2013
20 through 2018, or as provided in Section 5A-16, a hospital's
21 outpatient gross revenue shall be determined using the most
22 recent data available from each hospital's 2009 Medicare cost
23 report as contained in the Healthcare Cost Report Information
24 System file, for the quarter ending on June 30, 2011, without
25 regard to any subsequent adjustments or changes to such data.
26 If a hospital's 2009 Medicare cost report is not contained in

1 the Healthcare Cost Report Information System, then the
2 Department may obtain the hospital provider's outpatient gross
3 revenue from any source available, including, but not limited
4 to, records maintained by the hospital provider, which may be
5 inspected at all times during business hours of the day by the
6 Department or its duly authorized agents and employees.

7 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
8 fiscal years 2019 and 2020, an annual assessment on outpatient
9 services is imposed on each hospital provider in an amount
10 equal to .01358 multiplied by the hospital's outpatient gross
11 revenue; ~~however, for State fiscal year 2021, the amount of~~
12 ~~.01358 shall be increased by a uniform percentage to generate~~
13 ~~an additional \$6,250,000 in the aggregate for that period from~~
14 ~~all hospitals subject to the annual assessment under this~~
15 ~~paragraph.~~ For State fiscal years 2019 and 2020, a hospital's
16 outpatient gross revenue shall be determined using the most
17 recent data available from each hospital's 2015 Medicare cost
18 report as contained in the Healthcare Cost Report Information
19 System file, for the quarter ending on March 31, 2017, without
20 regard to any subsequent adjustments or changes to such data.
21 If a hospital's 2015 Medicare cost report is not contained in
22 the Healthcare Cost Report Information System, then the
23 Department may obtain the hospital provider's outpatient gross
24 revenue from any source available, including, but not limited
25 to, records maintained by the hospital provider, which may be
26 inspected at all times during business hours of the day by the

1 Department or its duly authorized agents and employees.
2 Notwithstanding any other provision in this Article, for a
3 hospital provider that did not have a 2015 Medicare cost
4 report, but paid an assessment in State fiscal year 2018 on the
5 basis of hypothetical data, that assessment amount shall be
6 used for State fiscal years 2019 and 2020, ~~however, for State~~
7 ~~fiscal year 2021, the assessment amount shall be increased by~~
8 ~~the proportion that it represents of the total annual~~
9 ~~assessment that is generated from all hospitals in order to~~
10 ~~generate \$6,250,000 in the aggregate for that period from all~~
11 ~~hospitals subject to the annual assessment under this~~
12 ~~paragraph.~~

13 (4) Subject to Sections 5A-3 and 5A-10, for the period of
14 July 1, 2020 through December 31, 2020 and calendar ~~State~~
15 ~~fiscal~~ years 2021 and 2022 ~~through 2024~~, an annual assessment
16 on outpatient services is imposed on each hospital provider in
17 an amount equal to .01525 ~~.01358~~ multiplied by the hospital's
18 outpatient gross revenue, provided however: (i) for the period
19 of July 1, 2020 through December 31, 2020, the assessment shall
20 be equal to 50% of the annual amount; and (ii) the amount of
21 .01525 shall be retroactively adjusted by a uniform percentage
22 to generate an amount equal to 50% of the Assessment
23 Adjustment, as defined in subsection (b-7), ~~that the amount of~~
24 ~~.01358~~ used to calculate the assessment under this paragraph
25 shall, by rule, be adjusted by a uniform percentage to generate
26 the same total annual assessment that was generated in State

1 ~~fiscal year 2020 from all hospitals subject to the annual~~
2 ~~assessment under this paragraph plus \$6,250,000. For the period~~
3 of July 1, 2020 through December 31, 2020 and calendar State
4 ~~fiscal~~ years 2021 and 2022, a hospital's outpatient gross
5 revenue shall be determined using the most recent data
6 available from each hospital's 2015 ~~2017~~ Medicare cost report
7 as contained in the Healthcare Cost Report Information System
8 file, for the quarter ending on March 31, 2017 ~~2019~~, without
9 regard to any subsequent adjustments or changes to such data.
10 If a hospital's 2015 Medicare cost report is not contained in
11 the Healthcare Cost Report Information System, then the
12 Illinois Department may obtain the hospital provider's
13 outpatient revenue data from any source available, including,
14 but not limited to, records maintained by the hospital
15 provider, which may be inspected at all times during business
16 hours of the day by the Illinois Department or its duly
17 authorized agents and employees. Should the change in the
18 assessment methodology above for fiscal years 2021 through
19 calendar year 2022 not be approved prior to July 1, 2020, the
20 assessment and payments under this Article in effect for fiscal
21 year 2020 shall remain in place until the new assessment is
22 approved. If the change in the assessment methodology above for
23 July 1, 2020 through December 31, 2022, is approved after June
24 30, 2020, it shall have a retroactive effective date of July 1,
25 2020, subject to federal approval and provided that the
26 payments authorized under Section 12A-7 have the same effective

1 date as the new assessment methodology. In giving retroactive
2 effect to the assessment approved after June 30, 2020, credit
3 toward the new assessment shall be given for any payments of
4 the previous assessment for periods after June 30, 2020.
5 Notwithstanding any other provision of this Article, for a
6 hospital provider that did not have a 2015 Medicare cost
7 report, but paid an assessment in State Fiscal Year 2020 on the
8 basis of hypothetical data, the data that was the basis for the
9 2020 assessment shall be used to calculate the assessment under
10 this paragraph. For State fiscal years 2023 and 2024, a
11 hospital's outpatient gross revenue shall be determined using
12 the most recent data available from each hospital's 2019
13 Medicare cost report as contained in the Healthcare Cost Report
14 Information System file, for the quarter ending on March 31,
15 2021, without regard to any subsequent adjustments or changes
16 to such data.

17 (b-6) (1) As used in this Section, "ACA Assessment
18 Adjustment" means:

19 (A) For the period of July 1, 2016 through December 31,
20 2016, the product of .19125 multiplied by the sum of the
21 fee-for-service payments to hospitals as authorized under
22 Section 5A-12.5 and the adjustments authorized under
23 subsection (t) of Section 5A-12.2 to managed care
24 organizations for hospital services due and payable in the
25 month of April 2016 multiplied by 6.

26 (B) For the period of January 1, 2017 through June 30,

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

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

1 described in subparagraph (B).

2 (D) For the period of January 1, 2018 through June 30,
3 2018, 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 2017 multiplied by 6, except that:

9 (i) the amount calculated under this subparagraph

10 (D) shall be adjusted, either positively or
11 negatively, to account for the difference between the
12 actual payments issued under Section 5A-12.5 for the
13 period of July 1, 2017 through December 31, 2017 and
14 the estimated payments due and payable in the month of
15 April 2017 multiplied by 6 as described in subparagraph
16 (C); and

17 (ii) the amount calculated under this subparagraph
18 (D) shall be adjusted to include the product of .19125
19 multiplied by the sum of the fee-for-service payments,
20 if any, estimated to be paid to hospitals under
21 subsection (b) of Section 5A-12.5.

22 (2) The Department shall complete and apply a final
23 reconciliation of the ACA Assessment Adjustment prior to June
24 30, 2018 to account for:

25 (A) any differences between the actual payments issued
26 or scheduled to be issued prior to June 30, 2018 as

1 authorized in Section 5A-12.5 for the period of January 1,
2 2018 through June 30, 2018 and the estimated payments due
3 and payable in the month of October 2017 multiplied by 6 as
4 described in subparagraph (D); and

5 (B) any difference between the estimated
6 fee-for-service payments under subsection (b) of Section
7 5A-12.5 and the amount of such payments that are actually
8 scheduled to be paid.

9 The Department shall notify hospitals of any additional
10 amounts owed or reduction credits to be applied to the June
11 2018 ACA Assessment Adjustment. This is to be considered the
12 final reconciliation for the ACA Assessment Adjustment.

13 (3) Notwithstanding any other provision of this Section, if
14 for any reason the scheduled payments under subsection (b) of
15 Section 5A-12.5 are not issued in full by the final day of the
16 period authorized under subsection (b) of Section 5A-12.5,
17 funds collected from each hospital pursuant to subparagraph (D)
18 of paragraph (1) and pursuant to paragraph (2), attributable to
19 the scheduled payments authorized under subsection (b) of
20 Section 5A-12.5 that are not issued in full by the final day of
21 the period attributable to each payment authorized under
22 subsection (b) of Section 5A-12.5, shall be refunded.

23 (4) The increases authorized under paragraph (2) of
24 subsection (a) and paragraph (2) of subsection (b-5) shall be
25 limited to the federally required State share of the total
26 payments authorized under Section 5A-12.5 if the sum of such

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

7 (b-7)(1) As used in this Section, "Assessment Adjustment"
8 means:

9 (A) For the period of July 1, 2020 through December 31,
10 2020, the product of .3853 multiplied by the total of the
11 actual payments made under subsections (c) through (k) of
12 Section 5A-12.7 attributable to the period, less the total
13 of the assessment imposed under subsections (a) and (b-5)
14 of this Section for the period.

15 (B) For each calendar quarter beginning on and after
16 January 1, 2021, the product of .3853 multiplied by the
17 total of the actual payments made under subsections (c)
18 through (k) of Section 5A-12.7 attributable to the period,
19 less the total of the assessment imposed under subsections
20 (a) and (b-5) of this Section for the period.

21 (2) The Department shall calculate and notify each hospital
22 of the total Assessment Adjustment and any additional
23 assessment owed by the hospital or refund owed to the hospital
24 on either a semi-annual or annual basis. Such notice shall be
25 issued at least 30 days prior to any period in which the
26 assessment will be adjusted. Any additional assessment owed by

1 the hospital or refund owed to the hospital shall be uniformly
2 applied to the assessment owed by the hospital in monthly
3 installments for the subsequent semi-annual period or calendar
4 year. If no assessment is owed in the subsequent year, any
5 amount owed by the hospital or refund due to the hospital,
6 shall be paid in a lump sum.

7 (3) The Department shall publish all details of the
8 Assessment Adjustment calculation performed each year on its
9 website within 30 days of completing the calculation, and also
10 submit the details of the Assessment Adjustment calculation as
11 part of the Department's annual report to the General Assembly.

12 (c) (Blank).

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

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

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

17 (Source: P.A. 100-581, eff. 3-12-18; 101-10, eff. 6-5-19.)

18 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

19 Sec. 5A-4. Payment of assessment; penalty.

20 (a) The assessment imposed by Section 5A-2 for State fiscal
21 year 2009 through State fiscal year 2018 or as provided in
22 Section 5A-16, shall be due and payable in monthly
23 installments, each equaling one-twelfth of the assessment for
24 the year, on the fourteenth State business day of each month.
25 No installment payment of an assessment imposed by Section 5A-2

1 shall be due and payable, however, until after the Comptroller
2 has issued the payments required under this Article.

3 Except as provided in subsection (a-5) of this Section, the
4 assessment imposed by subsection (b-5) of Section 5A-2 for the
5 portion of State fiscal year 2012 beginning June 10, 2012
6 through June 30, 2012, and for State fiscal year 2013 through
7 State fiscal year 2018 or as provided in Section 5A-16, shall
8 be due and payable in monthly installments, each equaling
9 one-twelfth of the assessment for the year, on the 17th State
10 business day of each month. No installment payment of an
11 assessment imposed by subsection (b-5) of Section 5A-2 shall be
12 due and payable, however, until after: (i) the Department
13 notifies the hospital provider, in writing, that the payment
14 methodologies to hospitals required under Section 5A-12.4,
15 have been approved by the Centers for Medicare and Medicaid
16 Services of the U.S. Department of Health and Human Services,
17 and the waiver under 42 CFR 433.68 for the assessment imposed
18 by subsection (b-5) of Section 5A-2, if necessary, has been
19 granted by the Centers for Medicare and Medicaid Services of
20 the U.S. Department of Health and Human Services; and (ii) the
21 Comptroller has issued the payments required under Section
22 5A-12.4. Upon notification to the Department of approval of the
23 payment methodologies required under Section 5A-12.4 and the
24 waiver granted under 42 CFR 433.68, if necessary, all
25 installments otherwise due under subsection (b-5) of Section
26 5A-2 prior to the date of notification shall be due and payable

1 to the Department upon written direction from the Department
2 and issuance by the Comptroller of the payments required under
3 Section 5A-12.4.

4 Except as provided in subsection (a-5) of this Section, the
5 assessment imposed under Section 5A-2 for State fiscal year
6 2019 and each subsequent State fiscal year shall be due and
7 payable in monthly installments, each equaling one-twelfth of
8 the assessment for the year, on the 17th State business day of
9 each month. The Department has discretion to establish a later
10 date due to delays in payments being made to hospitals as
11 required under Section 5A-12.7. No installment payment of an
12 assessment imposed by Section 5A-2 shall be due and payable,
13 however, until after: (i) the Department notifies the hospital
14 provider, in writing, that the payment methodologies to
15 hospitals required under Section 5A-12.6 or 5A-12.7 have been
16 approved by the Centers for Medicare and Medicaid Services of
17 the U.S. Department of Health and Human Services, and the
18 waiver under 42 CFR 433.68 for the assessment imposed by
19 Section 5A-2, if necessary, has been granted by the Centers for
20 Medicare and Medicaid Services of the U.S. Department of Health
21 and Human Services; and (ii) the Comptroller and managed care
22 organizations have ~~has~~ issued the payments required under
23 Section 5A-12.6 or 5A-12.7. Upon notification to the Department
24 of approval of the payment methodologies required under Section
25 5A-12.6 or 5A-12.7 and the waiver granted under 42 CFR 433.68,
26 if necessary, all installments otherwise due under Section 5A-2

1 prior to the date of notification shall be due and payable to
2 the Department upon written direction from the Department and
3 issuance by the Comptroller and managed care organizations of
4 the payments required under Section 5A-12.6 or 5A-12.7.

5 (a-5) The Illinois Department may accelerate the schedule
6 upon which assessment installments are due and payable by
7 hospitals with a payment ratio greater than or equal to one.
8 Such acceleration of due dates for payment of the assessment
9 may be made only in conjunction with a corresponding
10 acceleration in access payments identified in Section 5A-12.2,
11 Section 5A-12.4, ~~or~~ Section 5A-12.6, or Section 5A-12.7 to the
12 same hospitals. For the purposes of this subsection (a-5), a
13 hospital's payment ratio is defined as the quotient obtained by
14 dividing the total payments for the State fiscal year, as
15 authorized under Section 5A-12.2, Section 5A-12.4, ~~or~~ Section
16 5A-12.6, or Section 5A-12.7, by the total assessment for the
17 State fiscal year imposed under Section 5A-2 or subsection
18 (b-5) of Section 5A-2.

19 (b) The Illinois Department is authorized to establish
20 delayed payment schedules for hospital providers that are
21 unable to make installment payments when due under this Section
22 due to financial difficulties, as determined by the Illinois
23 Department.

24 (c) If a hospital provider fails to pay the full amount of
25 an installment when due (including any extensions granted under
26 subsection (b)), there shall, unless waived by the Illinois

1 Department for reasonable cause, be added to the assessment
2 imposed by Section 5A-2 a penalty assessment equal to the
3 lesser of (i) 5% of the amount of the installment not paid on
4 or before the due date plus 5% of the portion thereof remaining
5 unpaid on the last day of each 30-day period thereafter or (ii)
6 100% of the installment amount not paid on or before the due
7 date. For purposes of this subsection, payments will be
8 credited first to unpaid installment amounts (rather than to
9 penalty or interest), beginning with the most delinquent
10 installments.

11 (d) Any assessment amount that is due and payable to the
12 Illinois Department more frequently than once per calendar
13 quarter shall be remitted to the Illinois Department by the
14 hospital provider by means of electronic funds transfer. The
15 Illinois Department may provide for remittance by other means
16 if (i) the amount due is less than \$10,000 or (ii) electronic
17 funds transfer is unavailable for this purpose.

18 (Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19;
19 101-209, eff. 8-5-19.)

20 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

21 Sec. 5A-8. Hospital Provider Fund.

22 (a) There is created in the State Treasury the Hospital
23 Provider Fund. Interest earned by the Fund shall be credited to
24 the Fund. The Fund shall not be used to replace any moneys
25 appropriated to the Medicaid program by the General Assembly.

1 (b) The Fund is created for the purpose of receiving moneys
2 in accordance with Section 5A-6 and disbursing moneys only for
3 the following purposes, notwithstanding any other provision of
4 law:

5 (1) For making payments to hospitals as required under
6 this Code, under the Children's Health Insurance Program
7 Act, under the Covering ALL KIDS Health Insurance Act, and
8 under the Long Term Acute Care Hospital Quality Improvement
9 Transfer Program Act.

10 (2) For the reimbursement of moneys collected by the
11 Illinois Department from hospitals or hospital providers
12 through error or mistake in performing the activities
13 authorized under this Code.

14 (3) For payment of administrative expenses incurred by
15 the Illinois Department or its agent in performing
16 activities under this Code, under the Children's Health
17 Insurance Program Act, under the Covering ALL KIDS Health
18 Insurance Act, and under the Long Term Acute Care Hospital
19 Quality Improvement Transfer Program Act.

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

23 (5) For making transfers, as those transfers are
24 authorized in the proceedings authorizing debt under the
25 Short Term Borrowing Act, but transfers made under this
26 paragraph (5) shall not exceed the principal amount of debt

1 issued in anticipation of the receipt by the State of
2 moneys to be deposited into the Fund.

3 (6) For making transfers to any other fund in the State
4 treasury, but transfers made under this paragraph (6) shall
5 not exceed the amount transferred previously from that
6 other fund into the Hospital Provider Fund plus any
7 interest that would have been earned by that fund on the
8 monies that had been transferred.

9 (6.5) For making transfers to the Healthcare Provider
10 Relief Fund, except that transfers made under this
11 paragraph (6.5) shall not exceed \$60,000,000 in the
12 aggregate.

13 (7) For making transfers not exceeding the following
14 amounts, related to State fiscal years 2013 through 2018,
15 to the following designated funds:

16	Health and Human Services Medicaid Trust	
17	Fund	\$20,000,000
18	Long-Term Care Provider Fund	\$30,000,000
19	General Revenue Fund	\$80,000,000.

20 Transfers under this paragraph shall be made within 7 days
21 after the payments have been received pursuant to the
22 schedule of payments provided in subsection (a) of Section
23 5A-4.

24 (7.1) (Blank).

25 (7.5) (Blank).

26 (7.8) (Blank).

1 (7.9) (Blank).

2 (7.10) For State fiscal year 2014, for making transfers
3 of the moneys resulting from the assessment under
4 subsection (b-5) of Section 5A-2 and received from hospital
5 providers under Section 5A-4 and transferred into the
6 Hospital Provider Fund under Section 5A-6 to the designated
7 funds not exceeding the following amounts in that State
8 fiscal year:

9 Healthcare Provider Relief Fund \$100,000,000

10 Transfers under this paragraph shall be made within 7
11 days after the payments have been received pursuant to the
12 schedule of payments provided in subsection (a) of Section
13 5A-4.

14 The additional amount of transfers in this paragraph
15 (7.10), authorized by Public Act 98-651, shall be made
16 within 10 State business days after June 16, 2014 (the
17 effective date of Public Act 98-651). That authority shall
18 remain in effect even if Public Act 98-651 does not become
19 law until State fiscal year 2015.

20 (7.10a) For State fiscal years 2015 through 2018, for
21 making transfers of the moneys resulting from the
22 assessment under subsection (b-5) of Section 5A-2 and
23 received from hospital providers under Section 5A-4 and
24 transferred into the Hospital Provider Fund under Section
25 5A-6 to the designated funds not exceeding the following
26 amounts related to each State fiscal year:

1 Healthcare Provider Relief Fund \$50,000,000

2 Transfers under this paragraph shall be made within 7
3 days after the payments have been received pursuant to the
4 schedule of payments provided in subsection (a) of Section
5 5A-4.

6 (7.11) (Blank).

7 (7.12) For State fiscal year 2013, for increasing by
8 21/365ths the transfer of the moneys resulting from the
9 assessment under subsection (b-5) of Section 5A-2 and
10 received from hospital providers under Section 5A-4 for the
11 portion of State fiscal year 2012 beginning June 10, 2012
12 through June 30, 2012 and transferred into the Hospital
13 Provider Fund under Section 5A-6 to the designated funds
14 not exceeding the following amounts in that State fiscal
15 year:

16 Healthcare Provider Relief Fund \$2,870,000

17 Since the federal Centers for Medicare and Medicaid
18 Services approval of the assessment authorized under
19 subsection (b-5) of Section 5A-2, received from hospital
20 providers under Section 5A-4 and the payment methodologies
21 to hospitals required under Section 5A-12.4 was not
22 received by the Department until State fiscal year 2014 and
23 since the Department made retroactive payments during
24 State fiscal year 2014 related to the referenced period of
25 June 2012, the transfer authority granted in this paragraph
26 (7.12) is extended through the date that is 10 State

1 business days after June 16, 2014 (the effective date of
2 Public Act 98-651).

3 (7.13) In addition to any other transfers authorized
4 under this Section, for State fiscal years 2017 and 2018,
5 for making transfers to the Healthcare Provider Relief Fund
6 of moneys collected from the ACA Assessment Adjustment
7 authorized under subsections (a) and (b-5) of Section 5A-2
8 and paid by hospital providers under Section 5A-4 into the
9 Hospital Provider Fund under Section 5A-6 for each State
10 fiscal year. Timing of transfers to the Healthcare Provider
11 Relief Fund under this paragraph shall be at the discretion
12 of the Department, but no less frequently than quarterly.

13 (7.14) For making transfers not exceeding the
14 following amounts, related to State fiscal years 2019 and
15 2020 through 2024, to the following designated funds:

16	Health and Human Services Medicaid Trust	
17	Fund	\$20,000,000
18	Long-Term Care Provider Fund	\$30,000,000
19	<u>Healthcare</u> Health Care Provider Relief Fund	
20		\$325,000,000.

21 Transfers under this paragraph shall be made within 7
22 days after the payments have been received pursuant to the
23 schedule of payments provided in subsection (a) of Section
24 5A-4.

25 (7.15) For making transfers not exceeding the
26 following amounts, related to State fiscal years 2021 and

1 2022, to the following designated funds:

2 Health and Human Services Medicaid Trust

3 Fund \$20,000,000

4 Long-Term Care Provider Fund \$30,000,000

5 Healthcare Provider Relief Fund \$365,000,000

6 (7.16) For making transfers not exceeding the
7 following amounts, related to July 1, 2022 to December 31,
8 2022, to the following designated funds:

9 Health and Human Services Medicaid Trust

10 Fund \$10,000,000

11 Long-Term Care Provider Fund \$15,000,000

12 Healthcare Provider Relief Fund \$182,500,000

13 (8) For making refunds to hospital providers pursuant
14 to Section 5A-10.

15 (9) For making payment to capitated managed care
16 organizations as described in subsections (s) and (t) of
17 Section 5A-12.2, ~~and~~ subsection (r) of Section 5A-12.6, and
18 Section 5A-12.7 of this Code.

19 Disbursements from the Fund, other than transfers
20 authorized under paragraphs (5) and (6) of this subsection,
21 shall be by warrants drawn by the State Comptroller upon
22 receipt of vouchers duly executed and certified by the Illinois
23 Department.

24 (c) The Fund shall consist of the following:

25 (1) All moneys collected or received by the Illinois
26 Department from the hospital provider assessment imposed

1 by this Article.

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

6 (3) Any interest or penalty levied in conjunction with
7 the administration of this Article.

8 (3.5) As applicable, proceeds from surety bond
9 payments payable to the Department as referenced in
10 subsection (s) of Section 5A-12.2 of this Code.

11 (4) Moneys transferred from another fund in the State
12 treasury.

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

15 (d) (Blank).

16 (Source: P.A. 99-78, eff. 7-20-15; 99-516, eff. 6-30-16;
17 99-933, eff. 1-27-17; 100-581, eff. 3-12-18; 100-863, eff.
18 8-14-19; revised 7-12-19.)

19 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

20 Sec. 5A-10. Applicability.

21 (a) The assessment imposed by subsection (a) of Section
22 5A-2 shall cease to be imposed and the Department's obligation
23 to make payments shall immediately cease, and any moneys
24 remaining in the Fund shall be refunded to hospital providers
25 in proportion to the amounts paid by them, if:

1 (1) The payments to hospitals required under this
2 Article are not eligible for federal matching funds under
3 Title XIX or XXI of the Social Security Act;

4 (2) For State fiscal years 2009 through 2018, and as
5 provided in Section 5A-16, the Department of Healthcare and
6 Family Services adopts any administrative rule change to
7 reduce payment rates or alters any payment methodology that
8 reduces any payment rates made to operating hospitals under
9 the approved Title XIX or Title XXI State plan in effect
10 January 1, 2008 except for:

11 (A) any changes for hospitals described in
12 subsection (b) of Section 5A-3;

13 (B) any rates for payments made under this Article
14 V-A;

15 (C) any changes proposed in State plan amendment
16 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
17 08-07;

18 (D) in relation to any admissions on or after
19 January 1, 2011, a modification in the methodology for
20 calculating outlier payments to hospitals for
21 exceptionally costly stays, for hospitals reimbursed
22 under the diagnosis-related grouping methodology in
23 effect on July 1, 2011; provided that the Department
24 shall be limited to one such modification during the
25 36-month period after the effective date of this
26 amendatory Act of the 96th General Assembly;

1 (E) any changes affecting hospitals authorized by
2 Public Act 97-689;

3 (F) any changes authorized by Section 14-12 of this
4 Code, or for any changes authorized under Section 5A-15
5 of this Code; or

6 (G) any changes authorized under Section 5-5b.1.

7 (b) The assessment imposed by Section 5A-2 shall not take
8 effect or shall cease to be imposed, and the Department's
9 obligation to make payments shall immediately cease, if the
10 assessment is determined to be an impermissible tax under Title
11 XIX of the Social Security Act. Moneys in the Hospital Provider
12 Fund derived from assessments imposed prior thereto shall be
13 disbursed in accordance with Section 5A-8 to the extent federal
14 financial participation is not reduced due to the
15 impermissibility of the assessments, and any remaining moneys
16 shall be refunded to hospital providers in proportion to the
17 amounts paid by them.

18 (c) The assessments imposed by subsection (b-5) of Section
19 5A-2 shall not take effect or shall cease to be imposed, the
20 Department's obligation to make payments shall immediately
21 cease, and any moneys remaining in the Fund shall be refunded
22 to hospital providers in proportion to the amounts paid by
23 them, if the payments to hospitals required under Section
24 5A-12.4 or Section 5A-12.6 are not eligible for federal
25 matching funds under Title XIX of the Social Security Act.

26 (d) The assessments imposed by Section 5A-2 shall not take

1 effect or shall cease to be imposed, the Department's
2 obligation to make payments shall immediately cease, and any
3 moneys remaining in the Fund shall be refunded to hospital
4 providers in proportion to the amounts paid by them, if:

5 (1) for State fiscal years 2013 through 2018, and as
6 provided in Section 5A-16, the Department reduces any
7 payment rates to hospitals as in effect on May 1, 2012, or
8 alters any payment methodology as in effect on May 1, 2012,
9 that has the effect of reducing payment rates to hospitals,
10 except for any changes affecting hospitals authorized in
11 Public Act 97-689 and any changes authorized by Section
12 14-12 of this Code, and except for any changes authorized
13 under Section 5A-15, and except for any changes authorized
14 under Section 5-5b.1;

15 (2) for State fiscal years 2013 through 2018, and as
16 provided in Section 5A-16, the Department reduces any
17 supplemental payments made to hospitals below the amounts
18 paid for services provided in State fiscal year 2011 as
19 implemented by administrative rules adopted and in effect
20 on or prior to June 30, 2011, except for any changes
21 affecting hospitals authorized in Public Act 97-689 and any
22 changes authorized by Section 14-12 of this Code, and
23 except for any changes authorized under Section 5A-15, and
24 except for any changes authorized under Section 5-5b.1; or

25 (3) for State fiscal years 2015 through 2018, and as
26 provided in Section 5A-16, the Department reduces the

1 overall effective rate of reimbursement to hospitals below
2 the level authorized under Section 14-12 of this Code,
3 except for any changes under Section 14-12 or Section 5A-15
4 of this Code, and except for any changes authorized under
5 Section 5-5b.1.

6 (e) In ~~Beginning in~~ State fiscal year 2019 through State
7 fiscal year 2020, the assessments imposed under Section 5A-2
8 shall not take effect or shall cease to be imposed, the
9 Department's obligation to make payments shall immediately
10 cease, and any moneys remaining in the Fund shall be refunded
11 to hospital providers in proportion to the amounts paid by
12 them, if:

13 (1) the payments to hospitals required under Section
14 5A-12.6 are not eligible for federal matching funds under
15 Title XIX of the Social Security Act; or

16 (2) the Department reduces the overall effective rate
17 of reimbursement to hospitals below the level authorized
18 under Section 14-12 of this Code, as in effect on December
19 31, 2017, except for any changes authorized under Sections
20 14-12 or Section 5A-15 of this Code, and except for any
21 changes authorized under changes to Sections 5A-12.2,
22 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by Public Act
23 100-581 ~~this amendatory Act of the 100th General Assembly~~.

24 (f) Beginning in State Fiscal Year 2021, the assessments
25 imposed under Section 5A-2 shall not take effect or shall cease
26 to be imposed, the Department's obligation to make payments

1 shall immediately cease, and any moneys remaining in the Fund
2 shall be refunded to hospital providers in proportion to the
3 amounts paid by them, if:

4 (1) the payments to hospitals required under Section
5 5A-12.7 are not eligible for federal matching funds under
6 Title XIX of the Social Security Act; or

7 (2) the Department reduces the overall effective rate
8 of reimbursement to hospitals below the level authorized
9 under Section 14-12, as in effect on December 31, 2019,
10 except for any changes authorized under Sections 14-12 or
11 5A-15, and except for any changes authorized under changes
12 to Sections 5A-12.7 and 14-12 made by this amendatory Act
13 of the 101st General Assembly.

14 (Source: P.A. 99-2, eff. 3-26-15; 100-581, eff. 3-12-18.)

15 (305 ILCS 5/5A-12.7 new)

16 Sec. 5A-12.7. Continuation of hospital access payments on
17 and after July 1, 2020.

18 (a) To preserve and improve access to hospital services,
19 for hospital services rendered on and after July 1, 2020, the
20 Department shall, except for hospitals described in subsection
21 (b) of Section 5A-3, make payments to hospitals or require
22 capitated managed care organizations to make payments as set
23 forth in this Section. Payments under this Section are not due
24 and payable, however, until: (i) the methodologies described in
25 this Section are approved by the federal government in an

1 appropriate State Plan amendment or directed payment preprint;
2 and (ii) the assessment imposed under this Article is
3 determined to be a permissible tax under Title XIX of the
4 Social Security Act. In determining the hospital access
5 payments authorized under subsection (g) of this Section, if a
6 hospital ceases to qualify for payments from the pool, the
7 payments for all hospitals continuing to qualify for payments
8 from such pool shall be uniformly adjusted to fully expend the
9 aggregate net amount of the pool, with such adjustment being
10 effective on the first day of the second month following the
11 date the hospital ceases to receive payments from such pool.

12 (b) Amounts moved into claims-based rates and distributed
13 in accordance with Section 14-12 shall remain in those
14 claims-based rates.

15 (c) Graduate medical education.

16 (1) The calculation of graduate medical education
17 payments shall be based on the hospital's Medicare cost
18 report ending in Calendar Year 2018, as reported in the
19 Healthcare Cost Report Information System file, release
20 date September 30, 2019. An Illinois hospital reporting
21 intern and resident cost on its Medicare cost report shall
22 be eligible for graduate medical education payments.

23 (2) Each hospital's annualized Medicaid Intern
24 Resident Cost is calculated using annualized intern and
25 resident total costs obtained from Worksheet B Part I,
26 Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93,

1 96-98, and 105-112 multiplied by the percentage that the
2 hospital's Medicaid days (Worksheet S3 Part I, Column 7,
3 Lines 2, 3, 4, 14, 16-18, and 32) comprise of the
4 hospital's total days (Worksheet S3 Part I, Column 8, Lines
5 14, 16-18, and 32).

6 (3) An annualized Medicaid indirect medical education
7 (IME) payment is calculated for each hospital using its IME
8 payments (Worksheet E Part A, Line 29, Column 1) multiplied
9 by the percentage that its Medicaid days (Worksheet S3 Part
10 I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of
11 its Medicare days (Worksheet S3 Part I, Column 6, Lines 2,
12 3, 4, 14, and 16-18).

13 (4) For each hospital, its annualized Medicaid Intern
14 Resident Cost and its annualized Medicaid IME payment are
15 summed, and, except as capped at 120% of the average cost
16 per intern and resident for all qualifying hospitals as
17 calculated under this paragraph, is multiplied by 22.6% to
18 determine the hospital's final graduate medical education
19 payment. Each hospital's average cost per intern and
20 resident shall be calculated by summing its total
21 annualized Medicaid Intern Resident Cost plus its
22 annualized Medicaid IME payment and dividing that amount by
23 the hospital's total Full Time Equivalent Residents and
24 Interns. If the hospital's average per intern and resident
25 cost is greater than 120% of the same calculation for all
26 qualifying hospitals, the hospital's per intern and

1 resident cost shall be capped at 120% of the average cost
2 for all qualifying hospitals.

3 (d) Fee-for-service supplemental payments. Each Illinois
4 hospital shall receive an annual payment equal to the amounts
5 below, to be paid in 12 equal installments on or before the
6 seventh State business day of each month, except that no
7 payment shall be due within 30 days after the later of the date
8 of notification of federal approval of the payment
9 methodologies required under this Section or any waiver
10 required under 42 CFR 433.68, at which time the sum of amounts
11 required under this Section prior to the date of notification
12 is due and payable.

13 (1) For critical access hospitals, \$385 per covered
14 inpatient day contained in paid fee-for-service claims and
15 \$530 per paid fee-for-service outpatient claim for dates of
16 service in Calendar Year 2019 in the Department's
17 Enterprise Data Warehouse as of May 11, 2020.

18 (2) For safety-net hospitals, \$960 per covered
19 inpatient day contained in paid fee-for-service claims and
20 \$625 per paid fee-for-service outpatient claim for dates of
21 service in Calendar Year 2019 in the Department's
22 Enterprise Data Warehouse as of May 11, 2020.

23 (3) For long term acute care hospitals, \$295 per
24 covered inpatient day contained in paid fee-for-service
25 claims for dates of service in Calendar Year 2019 in the
26 Department's Enterprise Data Warehouse as of May 11, 2020.

1 (4) For freestanding psychiatric hospitals, \$125 per
2 covered inpatient day contained in paid fee-for-service
3 claims and \$130 per paid fee-for-service outpatient claim
4 for dates of service in Calendar Year 2019 in the
5 Department's Enterprise Data Warehouse as of May 11, 2020.

6 (5) For freestanding rehabilitation hospitals, \$355
7 per covered inpatient day contained in paid
8 fee-for-service claims for dates of service in Calendar
9 Year 2019 in the Department's Enterprise Data Warehouse as
10 of May 11, 2020.

11 (6) For all general acute care hospitals and high
12 Medicaid hospitals as defined in subsection (f), \$350 per
13 covered inpatient day for dates of service in Calendar Year
14 2019 contained in paid fee-for-service claims and \$620 per
15 paid fee-for-service outpatient claim in the Department's
16 Enterprise Data Warehouse as of May 11, 2020.

17 (7) Alzheimer's treatment access payment. Each
18 Illinois academic medical center or teaching hospital, as
19 defined in Section 5-5e.2 of this Code, that is identified
20 as the primary hospital affiliate of one of the Regional
21 Alzheimer's Disease Assistance Centers, as designated by
22 the Alzheimer's Disease Assistance Act and identified in
23 the Department of Public Health's Alzheimer's Disease
24 State Plan dated December 2016, shall be paid an
25 Alzheimer's treatment access payment equal to the product
26 of the qualifying hospital's State Fiscal Year 2018 total

1 inpatient fee-for-service days multiplied by the
2 applicable Alzheimer's treatment rate of \$226.30 for
3 hospitals located in Cook County and \$116.21 for hospitals
4 located outside Cook County.

5 (e) The Department shall require managed care
6 organizations (MCOs) to make directed payments and
7 pass-through payments according to this Section. Each calendar
8 year, the Department shall require MCOs to pay the maximum
9 amount out of these funds as allowed as pass-through payments
10 under federal regulations. The Department shall require MCOs to
11 make such pass-through payments as specified in this Section.
12 The Department shall require the MCOs to pay the remaining
13 amounts as directed Payments as specified in this Section. The
14 Department shall issue payments to the Comptroller by the
15 seventh business day of each month for all MCOs that are
16 sufficient for MCOs to make the directed payments and
17 pass-through payments according to this Section. The
18 Department shall require the MCOs to make pass-through payments
19 and directed payments using electronic funds transfers (EFT),
20 if the hospital provides the information necessary to process
21 such EFTs, in accordance with directions provided monthly by
22 the Department, within 7 business days of the date the funds
23 are paid to the MCOs, as indicated by the "Paid Date" on the
24 website of the Office of the Comptroller if the funds are paid
25 by EFT and the MCOs have received directed payment
26 instructions. If funds are not paid through the Comptroller by

1 EFT, payment must be made within 7 business days of the date
2 actually received by the MCO. The MCO will be considered to
3 have paid the pass-through payments when the payment remittance
4 number is generated or the date the MCO sends the check to the
5 hospital, if EFT information is not supplied. If an MCO is late
6 in paying a pass-through payment or directed payment as
7 required under this Section (including any extensions granted
8 by the Department), it shall pay a penalty, unless waived by
9 the Department for reasonable cause, to the Department equal to
10 5% of the amount of the pass-through payment or directed
11 payment not paid on or before the due date plus 5% of the
12 portion thereof remaining unpaid on the last day of each 30-day
13 period thereafter. Payments to MCOs that would be paid
14 consistent with actuarial certification and enrollment in the
15 absence of the increased capitation payments under this Section
16 shall not be reduced as a consequence of payments made under
17 this subsection. The Department shall publish and maintain on
18 its website for a period of no less than 8 calendar quarters,
19 the quarterly calculation of directed payments and
20 pass-through payments owed to each hospital from each MCO. All
21 calculations and reports shall be posted no later than the
22 first day of the quarter for which the payments are to be
23 issued.

24 (f)(1) For purposes of allocating the funds included in
25 capitation payments to MCOs, Illinois hospitals shall be
26 divided into the following classes as defined in administrative

1 rules:

2 (A) Critical access hospitals.

3 (B) Safety-net hospitals, except that stand-alone
4 children's hospitals that are not specialty children's
5 hospitals will not be included.

6 (C) Long term acute care hospitals.

7 (D) Freestanding psychiatric hospitals.

8 (E) Freestanding rehabilitation hospitals.

9 (F) High Medicaid hospitals. As used in this Section,
10 "high Medicaid hospital" means a general acute care
11 hospital that is not a safety-net hospital or critical
12 access hospital and that has a Medicaid Inpatient
13 Utilization Rate above 30% or a hospital that had over
14 35,000 inpatient Medicaid days during the applicable
15 period. For the period July 1, 2020 through December 31,
16 2020, the applicable period for the Medicaid Inpatient
17 Utilization Rate (MIUR) is the rate year 2020 MIUR and for
18 the number of inpatient days it is State fiscal year 2018.
19 Beginning in calendar year 2021, the Department shall use
20 the most recently determined MIUR, as defined in subsection
21 (h) of Section 5-5.02, and for the inpatient day threshold,
22 the State fiscal year ending 18 months prior to the
23 beginning of the calendar year. For purposes of calculating
24 MIUR under this Section, children's hospitals and
25 affiliated general acute care hospitals shall be
26 considered a single hospital.

1 (G) General acute care hospitals. As used under this
2 Section, "general acute care hospitals" means all other
3 Illinois hospitals not identified in subparagraphs (A)
4 through (F).

5 (2) Hospitals' qualification for each class shall be
6 assessed prior to the beginning of each calendar year and the
7 new class designation shall be effective January 1 of the next
8 year. The Department shall publish by rule the process for
9 establishing class determination.

10 (g) Fixed pool directed payments. Beginning July 1, 2020,
11 the Department shall issue payments to MCOs which shall be used
12 to issue directed payments to qualified Illinois safety-net
13 hospitals and critical access hospitals on a monthly basis in
14 accordance with this subsection. Prior to the beginning of each
15 Payout Quarter beginning July 1, 2020, the Department shall use
16 encounter claims data from the Determination Quarter, accepted
17 by the Department's Medicaid Management Information System for
18 inpatient and outpatient services rendered by safety-net
19 hospitals and critical access hospitals to determine a
20 quarterly uniform per unit add-on for each hospital class.

21 (1) Inpatient per unit add-on. A quarterly uniform per
22 diem add-on shall be derived by dividing the quarterly
23 Inpatient Directed Payments Pool amount allocated to the
24 applicable hospital class by the total inpatient days
25 contained on all encounter claims received during the
26 Determination Quarter, for all hospitals in the class.

1 (A) Each hospital in the class shall have a
2 quarterly inpatient directed payment calculated that
3 is equal to the product of the number of inpatient days
4 attributable to the hospital used in the calculation of
5 the quarterly uniform class per diem add-on,
6 multiplied by the calculated applicable quarterly
7 uniform class per diem add-on of the hospital class.

8 (B) Each hospital shall be paid 1/3 of its
9 quarterly inpatient directed payment in each of the 3
10 months of the Payout Quarter, in accordance with
11 directions provided to each MCO by the Department.

12 (2) Outpatient per unit add-on. A quarterly uniform per
13 claim add-on shall be derived by dividing the quarterly
14 Outpatient Directed Payments Pool amount allocated to the
15 applicable hospital class by the total outpatient
16 encounter claims received during the Determination
17 Quarter, for all hospitals in the class.

18 (A) Each hospital in the class shall have a
19 quarterly outpatient directed payment calculated that
20 is equal to the product of the number of outpatient
21 encounter claims attributable to the hospital used in
22 the calculation of the quarterly uniform class per
23 claim add-on, multiplied by the calculated applicable
24 quarterly uniform class per claim add-on of the
25 hospital class.

26 (B) Each hospital shall be paid 1/3 of its

1 quarterly outpatient directed payment in each of the 3
2 months of the Payout Quarter, in accordance with
3 directions provided to each MCO by the Department.

4 (3) Each MCO shall pay each hospital the Monthly
5 Directed Payment as identified by the Department on its
6 quarterly determination report.

7 (4) Definitions. As used in this subsection:

8 (A) "Payout Quarter" means each 3 month calendar
9 quarter, beginning July 1, 2020.

10 (B) "Determination Quarter" means each 3 month
11 calendar quarter, which ends 3 months prior to the
12 first day of each Payout Quarter.

13 (5) For the period July 1, 2020 through December 2020,
14 the following amounts shall be allocated to the following
15 hospital class directed payment pools for the quarterly
16 development of a uniform per unit add-on:

17 (A) \$2,894,500 for hospital inpatient services for
18 critical access hospitals.

19 (B) \$4,294,374 for hospital outpatient services
20 for critical access hospitals.

21 (C) \$29,109,330 for hospital inpatient services
22 for safety-net hospitals.

23 (D) \$35,041,218 for hospital outpatient services
24 for safety-net hospitals.

25 (h) Fixed rate directed payments. Effective July 1, 2020,
26 the Department shall issue payments to MCOs which shall be used

1 to issue directed payments to Illinois hospitals not identified
2 in paragraph (g) on a monthly basis. Prior to the beginning of
3 each Payout Quarter beginning July 1, 2020, the Department
4 shall use encounter claims data from the Determination Quarter,
5 accepted by the Department's Medicaid Management Information
6 System for inpatient and outpatient services rendered by
7 hospitals in each hospital class identified in paragraph (f)
8 and not identified in paragraph (g). For the period July 1,
9 2020 through December 2020, the Department shall direct MCOs to
10 make payments as follows:

11 (1) For general acute care hospitals an amount equal to
12 \$1,750 multiplied by the hospital's category of service 20
13 case mix index for the determination quarter multiplied by
14 the hospital's total number of inpatient admissions for
15 category of service 20 for the determination quarter.

16 (2) For general acute care hospitals an amount equal to
17 \$160 multiplied by the hospital's category of service 21
18 case mix index for the determination quarter multiplied by
19 the hospital's total number of inpatient admissions for
20 category of service 21 for the determination quarter.

21 (3) For general acute care hospitals an amount equal to
22 \$80 multiplied by the hospital's category of service 22
23 case mix index for the determination quarter multiplied by
24 the hospital's total number of inpatient admissions for
25 category of service 22 for the determination quarter.

26 (4) For general acute care hospitals an amount equal to

1 \$375 multiplied by the hospital's category of service 24
2 case mix index for the determination quarter multiplied by
3 the hospital's total number of category of service 24 paid
4 EAPG (EAPGs) for the determination quarter.

5 (5) For general acute care hospitals an amount equal to
6 \$240 multiplied by the hospital's category of service 27
7 and 28 case mix index for the determination quarter
8 multiplied by the hospital's total number of category of
9 service 27 and 28 paid EAPGs for the determination quarter.

10 (6) For general acute care hospitals an amount equal to
11 \$290 multiplied by the hospital's category of service 29
12 case mix index for the determination quarter multiplied by
13 the hospital's total number of category of service 29 paid
14 EAPGs for the determination quarter.

15 (7) For high Medicaid hospitals an amount equal to
16 \$1,800 multiplied by the hospital's category of service 20
17 case mix index for the determination quarter multiplied by
18 the hospital's total number of inpatient admissions for
19 category of service 20 for the determination quarter.

20 (8) For high Medicaid hospitals an amount equal to \$160
21 multiplied by the hospital's category of service 21 case
22 mix index for the determination quarter multiplied by the
23 hospital's total number of inpatient admissions for
24 category of service 21 for the determination quarter.

25 (9) For high Medicaid hospitals an amount equal to \$80
26 multiplied by the hospital's category of service 22 case

1 mix index for the determination quarter multiplied by the
2 hospital's total number of inpatient admissions for
3 category of service 22 for the determination quarter.

4 (10) For high Medicaid hospitals an amount equal to
5 \$400 multiplied by the hospital's category of service 24
6 case mix index for the determination quarter multiplied by
7 the hospital's total number of category of service 24 paid
8 EAPG outpatient claims for the determination quarter.

9 (11) For high Medicaid hospitals an amount equal to
10 \$240 multiplied by the hospital's category of service 27
11 and 28 case mix index for the determination quarter
12 multiplied by the hospital's total number of category of
13 service 27 and 28 paid EAPGs for the determination quarter.

14 (12) For high Medicaid hospitals an amount equal to
15 \$290 multiplied by the hospital's category of service 29
16 case mix index for the determination quarter multiplied by
17 the hospital's total number of category of service 29 paid
18 EAPGs for the determination quarter.

19 (13) For long term acute care hospitals the amount of
20 \$495 multiplied by the hospital's total number of inpatient
21 days for the determination quarter.

22 (14) For psychiatric hospitals the amount of \$210
23 multiplied by the hospital's total number of inpatient days
24 for category of service 21 for the determination quarter.

25 (15) For psychiatric hospitals the amount of \$250
26 multiplied by the hospital's total number of outpatient

1 claims for category of service 27 and 28 for the
2 determination quarter.

3 (16) For rehabilitation hospitals the amount of \$410
4 multiplied by the hospital's total number of inpatient days
5 for category of service 22 for the determination quarter.

6 (17) For rehabilitation hospitals the amount of \$100
7 multiplied by the hospital's total number of outpatient
8 claims for category of service 29 for the determination
9 quarter.

10 (18) Each hospital shall be paid 1/3 of their quarterly
11 inpatient and outpatient directed payment in each of the 3
12 months of the Payout Quarter, in accordance with directions
13 provided to each MCO by the Department.

14 (19) Each MCO shall pay each hospital the Monthly
15 Directed Payment amount as identified by the Department on
16 its quarterly determination report.

17 Notwithstanding any other provision of this subsection, if
18 the Department determines that the actual total hospital
19 utilization data that is used to calculate the fixed rate
20 directed payments is substantially different than anticipated
21 when the rates in this subsection were initially determined
22 (for unforeseeable circumstances such as the COVID-19
23 pandemic), the Department may adjust the rates specified in
24 this subsection so that the total directed payments approximate
25 the total spending amount anticipated when the rates were
26 initially established.

1 Definitions. As used in this subsection:

2 (A) "Payout Quarter" means each calendar quarter,
3 beginning July 1, 2020.

4 (B) "Determination Quarter" means each calendar
5 quarter which ends 3 months prior to the first day of
6 each Payout Quarter.

7 (C) "Case mix index" means a hospital specific
8 calculation. For inpatient claims the case mix index is
9 calculated each quarter by summing the relative weight
10 of all inpatient Diagnosis-Related Group (DRG) claims
11 for a category of service in the applicable
12 Determination Quarter and dividing the sum by the
13 number of sum total of all inpatient DRG admissions for
14 the category of service for the associated claims. The
15 case mix index for outpatient claims is calculated each
16 quarter by summing the relative weight of all paid
17 EAPGs in the applicable Determination Quarter and
18 dividing the sum by the sum total of paid EAPGs for the
19 associated claims.

20 (i) Beginning January 1, 2021, the rates for directed
21 payments shall be recalculated in order to spend the additional
22 funds for directed payments that result from reduction in the
23 amount of pass-through payments allowed under federal
24 regulations. The additional funds for directed payments shall
25 be allocated proportionally to each class of hospitals based on
26 that class' proportion of services.

1 (j) Pass-through payments.

2 (1) For the period July 1, 2020 through December 31,
3 2020, the Department shall assign quarterly pass-through
4 payments to each class of hospitals equal to one-fourth of
5 the following annual allocations:

6 (A) \$390,487,095 to safety-net hospitals.

7 (B) \$62,553,886 to critical access hospitals.

8 (C) \$345,021,438 to high Medicaid hospitals.

9 (D) \$551,429,071 to general acute care hospitals.

10 (E) \$27,283,870 to long term acute care hospitals.

11 (F) \$40,825,444 to freestanding psychiatric
12 hospitals.

13 (G) \$9,652,108 to freestanding rehabilitation
14 hospitals.

15 (2) The pass-through payments shall at a minimum ensure
16 hospitals receive a total amount of monthly payments under
17 this Section as received in calendar year 2019 in
18 accordance with this Article and paragraph (1) of
19 subsection (d-5) of Section 14-12, exclusive of amounts
20 received through payments referenced in subsection (b).

21 (3) For the calendar year beginning January 1, 2021,
22 and each calendar year thereafter, each hospital's
23 pass-through payment amount shall be reduced
24 proportionally to the reduction of all pass-through
25 payments required by federal regulations.

26 (k) At least 30 days prior to each calendar year, the

1 Department shall notify each hospital of changes to the payment
2 methodologies in this Section, including, but not limited to,
3 changes in the fixed rate directed payment rates, the aggregate
4 pass-through payment amount for all hospitals, and the
5 hospital's pass-through payment amount for the upcoming
6 calendar year.

7 (l) Notwithstanding any other provisions of this Section,
8 the Department may adopt rules to change the methodology for
9 directed and pass-through payments as set forth in this
10 Section, but only to the extent necessary to obtain federal
11 approval of a necessary State Plan amendment or Directed
12 Payment Preprint or to otherwise conform to federal law or
13 federal regulation.

14 (m) As used in this subsection, "managed care organization"
15 or "MCO" means an entity which contracts with the Department to
16 provide services where payment for medical services is made on
17 a capitated basis, excluding contracted entities for dual
18 eligible or Department of Children and Family Services youth
19 populations.

20 (305 ILCS 5/5A-12.8 new)

21 Sec. 5A-12.8. Report to the General Assembly. In order to
22 facilitate transparency, accountability, and future policy
23 development by the General Assembly, the Department shall
24 provide the reports and information specified in this Section.
25 By February 1, 2022, the Department shall provide a report to

1 the General Assembly that includes, but is not limited to, the
2 following:

3 (1) information on the total payments made under
4 Section 5A-12.7 through December 1, 2021 broken out by
5 payment type; and

6 (2) after consulting the hospital community and other
7 interested parties, information that summarizes and
8 identifies options and stakeholder suggestions on the
9 following:

10 (A) policies and practices to improve access to
11 care, improve health, and reduce health disparities in
12 vulnerable communities;

13 (B) analysis of charity care by hospital;

14 (C) revisions to the payment methodology for
15 graduate medical education;

16 (D) revisions to the directed payment
17 methodologies, including the opportunity for hospitals
18 to shift from the fixed pool to the fixed rate directed
19 payments;

20 (E) the definitions of and criteria to qualify as a
21 safety-net hospital, a high Medicaid hospital, or a
22 children's hospital; and

23 (F) options to revise the methodology for
24 calculating the assessment under Section 5A-2.

1 Sec. 5A-13. Emergency rulemaking.

2 (a) The Department of Healthcare and Family Services
3 (formerly Department of Public Aid) may adopt rules necessary
4 to implement this amendatory Act of the 94th General Assembly
5 through the use of emergency rulemaking in accordance with
6 Section 5-45 of the Illinois Administrative Procedure Act. For
7 purposes of that Act, the General Assembly finds that the
8 adoption of rules to implement this amendatory Act of the 94th
9 General Assembly is deemed an emergency and necessary for the
10 public interest, safety, and welfare.

11 (b) The Department of Healthcare and Family Services may
12 adopt rules necessary to implement this amendatory Act of the
13 97th General Assembly through the use of emergency rulemaking
14 in accordance with Section 5-45 of the Illinois Administrative
15 Procedure Act. For purposes of that Act, the General Assembly
16 finds that the adoption of rules to implement this amendatory
17 Act of the 97th General Assembly is deemed an emergency and
18 necessary for the public interest, safety, and welfare.

19 (c) The Department of Healthcare and Family Services may
20 adopt rules necessary to initially implement the changes to
21 Articles 5, 5A, 12, and 14 of this Code under this amendatory
22 Act of the 100th General Assembly through the use of emergency
23 rulemaking in accordance with subsection (aa) of Section 5-45
24 of the Illinois Administrative Procedure Act. For purposes of
25 that Act, the General Assembly finds that the adoption of rules
26 to implement the changes to Articles 5, 5A, 12, and 14 of this

1 Code under this amendatory Act of the 100th General Assembly is
2 deemed an emergency and necessary for the public interest,
3 safety, and welfare. The 24-month limitation on the adoption of
4 emergency rules does not apply to rules adopted to initially
5 implement the changes to Articles 5, 5A, 12, and 14 of this
6 Code under this amendatory Act of the 100th General Assembly.
7 For purposes of this subsection, "initially" means any
8 emergency rules necessary to immediately implement the changes
9 authorized to Articles 5, 5A, 12, and 14 of this Code under
10 this amendatory Act of the 100th General Assembly; however,
11 emergency rulemaking authority shall not be used to make
12 changes that could otherwise be made following the process
13 established in the Illinois Administrative Procedure Act.

14 (d) The Department of Healthcare and Family Services may on
15 a one-time-only basis adopt rules necessary to initially
16 implement the changes to Articles 5A and 14 of this Code under
17 this amendatory Act of the 100th General Assembly through the
18 use of emergency rulemaking in accordance with subsection (ee)
19 of Section 5-45 of the Illinois Administrative Procedure Act.
20 For purposes of that Act, the General Assembly finds that the
21 adoption of rules on a one-time-only basis to implement the
22 changes to Articles 5A and 14 of this Code under this
23 amendatory Act of the 100th General Assembly is deemed an
24 emergency and necessary for the public interest, safety, and
25 welfare. The 24-month limitation on the adoption of emergency
26 rules does not apply to rules adopted to initially implement

1 the changes to Articles 5A and 14 of this Code under this
2 amendatory Act of the 100th General Assembly.

3 (e) The Department of Healthcare and Family Services may
4 adopt rules necessary to implement the changes made to Articles
5 5, 5A, 12, and 14 of this Code by this amendatory Act of the
6 101st General Assembly through the use of emergency rulemaking
7 in accordance with Section 5-45.1 of the Illinois
8 Administrative Procedure Act. The 24-month limitation on the
9 adoption of emergency rules does not apply to rules adopted
10 under this Section. The General Assembly finds that the
11 adoption of rules to implement the changes made to Articles 5,
12 5A, 12, and 14 of this Code by this amendatory Act of the 101st
13 General Assembly is deemed an emergency and necessary for the
14 public interest, safety, and welfare.

15 (Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19.)

16 (305 ILCS 5/5A-14)

17 Sec. 5A-14. Repeal of assessments and disbursements.

18 (a) Section 5A-2 is repealed on December 31, 2022 ~~July 1,~~
19 ~~2020~~.

20 (b) Section 5A-12 is repealed on July 1, 2005.

21 (c) Section 5A-12.1 is repealed on July 1, 2008.

22 (d) Section 5A-12.2 and Section 5A-12.4 are repealed on
23 July 1, 2018, subject to Section 5A-16.

24 (e) Section 5A-12.3 is repealed on July 1, 2011.

25 (f) Section 5A-12.6 is repealed on July 1, 2020.

1 (g) Section 5A-12.7 is repealed on December 31, 2022.

2 (Source: P.A. 100-581, eff. 3-12-18.)

3 (305 ILCS 5/5A-17 new)

4 Sec. 5A-17. Recovery of payments; liens.

5 (a) As a condition of receiving payments pursuant to
6 subsections (d) and (k) of Section 5A-12.7 for State Fiscal
7 Year 2021, a for-profit general acute care hospital that ceases
8 to provide hospital services before July 1, 2021 and within 12
9 months of a change in the hospital's ownership status from
10 not-for-profit to investor owned, shall be obligated to pay to
11 the Department an amount equal to the payments received
12 pursuant to subsections (d) and (k) of Section 5A-12.7 since
13 the change in ownership status to the cessation of hospital
14 services. The obligated amount shall be due immediately and
15 must be paid to the Department within 10 days of ceasing to
16 provide services or pursuant to a payment plan approved by the
17 Department unless the hospital requests a hearing under
18 paragraph (d) of this Section. The obligation under this
19 Section shall not apply to a hospital that ceases to provide
20 services under circumstances that include: implementation of a
21 transformation project approved by the Department under
22 subsection (d-5) of Section 14-12; emergencies as declared by
23 federal, State, or local government; actions approved or
24 required by federal, State, or local government; actions taken
25 in compliance with the Illinois Health Facilities Planning Act;

1 or other circumstances beyond the control of the hospital
2 provider or for the benefit of the community previously served
3 by the hospital, as determined on a case-by-case basis by the
4 Department.

5 (b) The Illinois Department shall administer and enforce
6 this Section and collect the obligations imposed under this
7 Section using procedures employed in its administration of this
8 Code generally. The Illinois Department, its Director, and
9 every hospital provider subject to this Section shall have the
10 following powers, duties, and rights:

11 (1) The Illinois Department may initiate either
12 administrative or judicial proceedings, or both, to
13 enforce the provisions of this Section. Administrative
14 enforcement proceedings initiated hereunder shall be
15 governed by the Illinois Department's administrative
16 rules. Judicial enforcement proceedings initiated in
17 accordance with this Section shall be governed by the rules
18 of procedure applicable in the courts of this State.

19 (2) No proceedings for collection, refund, credit, or
20 other adjustment of an amount payable under this Section
21 shall be issued more than 3 years after the due date of the
22 obligation, except in the case of an extended period agreed
23 to in writing by the Illinois Department and the hospital
24 provider before the expiration of this limitation period.

25 (3) Any unpaid obligation under this Section shall
26 become a lien upon the assets of the hospital. If any

1 hospital provider sells or transfers the major part of any
2 one or more of (i) the real property and improvements, (ii)
3 the machinery and equipment, or (iii) the furniture or
4 fixtures of any hospital that is subject to the provisions
5 of this Section, the seller or transferor shall pay the
6 Illinois Department the amount of any obligation due from
7 it under this Section up to the date of the sale or
8 transfer. If the seller or transferor fails to pay any
9 amount due under this Section, the purchaser or transferee
10 of such asset shall be liable for the amount of the
11 obligation up to the amount of the reasonable value of the
12 property acquired by the purchaser or transferee. The
13 purchaser or transferee shall continue to be liable until
14 the purchaser or transferee pays the full amount of the
15 obligation up to the amount of the reasonable value of the
16 property acquired by the purchaser or transferee or until
17 the purchaser or transferee receives from the Illinois
18 Department a certificate showing that such assessment,
19 penalty, and interest have been paid or a certificate from
20 the Illinois Department showing that no amount is due from
21 the seller or transferor under this Section.

22 (c) In addition to any other remedy provided for, the
23 Illinois Department may collect an unpaid obligation by
24 withholding, as payment of the amount due, reimbursements or
25 other amounts otherwise payable by the Illinois Department to
26 the hospital provider.

1 (305 ILCS 5/12-4.105)

2 Sec. 12-4.105. Human poison control center; payment
3 program. Subject to funding availability resulting from
4 transfers made from the Hospital Provider Fund to the
5 Healthcare Provider Relief Fund as authorized under this Code,
6 for State fiscal year 2017 and State fiscal year 2018, and for
7 each State fiscal year thereafter in which the assessment under
8 Section 5A-2 is imposed, the Department of Healthcare and
9 Family Services shall pay to the human poison control center
10 designated under the Poison Control System Act an amount of not
11 less than \$3,000,000 for each of ~~those~~ State fiscal years 2017
12 through 2020, and for State fiscal year 2021 and 2022 an amount
13 of not less than \$3,750,000 and for the period July 1, 2022
14 through December 31, 2022 an amount of not less than
15 \$1,875,000, if ~~that~~ the human poison control center is in
16 operation.

17 (Source: P.A. 99-516, eff. 6-30-16; 100-581, eff. 3-12-18.)

18 (305 ILCS 5/14-12)

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

22 (a) Inpatient hospital services. Effective for discharges
23 on and after July 1, 2014, reimbursement for inpatient general
24 acute care services shall utilize the All Patient Refined

1 Diagnosis Related Grouping (APR-DRG) software, version 30,
2 distributed by 3M™ Health Information System.

3 (1) The Department shall establish Medicaid weighting
4 factors to be used in the reimbursement system established
5 under this subsection. Initial weighting factors shall be
6 the weighting factors as published by 3M Health Information
7 System, associated with Version 30.0 adjusted for the
8 Illinois experience.

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

14 (3) In addition to the statewide-standardized amount,
15 the Department shall develop adjusters to adjust the rate
16 of reimbursement for critical Medicaid providers or
17 services for trauma, transplantation services, perinatal
18 care, and Graduate Medical Education (GME).

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

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

7 (6) Beginning July 1, 2014 and ending on June 30, 2024,
8 in addition to the statewide-standardized amount, the
9 Department shall develop an adjustor to adjust the rate of
10 reimbursement for safety-net hospitals defined in Section
11 5-5e.1 of this Code excluding pediatric hospitals.

12 (7) Beginning July 1, 2014 ~~and ending on June 30, 2020,~~
13 ~~or upon implementation of inpatient psychiatric rate~~
14 ~~increases as described in subsection (n) of Section~~
15 ~~5A-12.6,~~ in addition to the statewide-standardized amount,
16 the Department shall develop an adjustor to adjust the rate
17 of reimbursement for Illinois freestanding inpatient
18 psychiatric hospitals that are not designated as
19 children's hospitals by the Department but are primarily
20 treating patients under the age of 21.

21 (7.5) (Blank). ~~Beginning July 1, 2020, the~~
22 ~~reimbursement for inpatient psychiatric services shall be~~
23 ~~so that base claims projected reimbursement is increased by~~
24 ~~an amount equal to the funds allocated in paragraph (2) of~~
25 ~~subsection (b) of Section 5A-12.6, less the amount~~
26 ~~allocated under paragraphs (8) and (9) of this subsection~~

1 ~~and paragraphs (3) and (4) of subsection (b) multiplied by~~
2 ~~13%. Beginning July 1, 2022, the reimbursement for~~
3 ~~inpatient psychiatric services shall be so that base claims~~
4 ~~projected reimbursement is increased by an amount equal to~~
5 ~~the funds allocated in paragraph (3) of subsection (b) of~~
6 ~~Section 5A 12.6, less the amount allocated under~~
7 ~~paragraphs (8) and (9) of this subsection and paragraphs~~
8 ~~(3) and (4) of subsection (b) multiplied by 13%. Beginning~~
9 ~~July 1, 2024, the reimbursement for inpatient psychiatric~~
10 ~~services shall be so that base claims projected~~
11 ~~reimbursement is increased by an amount equal to the funds~~
12 ~~allocated in paragraph (4) of subsection (b) of Section~~
13 ~~5A 12.6, less the amount allocated under paragraphs (8) and~~
14 ~~(9) of this subsection and paragraphs (3) and (4) of~~
15 ~~subsection (b) multiplied by 13%.~~

16 (8) Beginning July 1, 2018, in addition to the
17 statewide-standardized amount, the Department shall adjust
18 the rate of reimbursement for hospitals designated by the
19 Department of Public Health as a Perinatal Level II or II+
20 center by applying the same adjustor that is applied to
21 Perinatal and Obstetrical care cases for Perinatal Level
22 III centers, as of December 31, 2017.

23 (9) Beginning July 1, 2018, in addition to the
24 statewide-standardized amount, the Department shall apply
25 the same adjustor that is applied to trauma cases as of
26 December 31, 2017 to inpatient claims to treat patients

1 with burns, including, but not limited to, APR-DRGs 841,
2 842, 843, and 844.

3 (10) Beginning July 1, 2018, the
4 statewide-standardized amount for inpatient general acute
5 care services shall be uniformly increased so that base
6 claims projected reimbursement is increased by an amount
7 equal to the funds allocated in paragraph (1) of subsection
8 (b) of Section 5A-12.6, less the amount allocated under
9 paragraphs (8) and (9) of this subsection and paragraphs
10 (3) and (4) of subsection (b) multiplied by 40%. ~~Beginning~~
11 ~~July 1, 2020, the statewide-standardized amount for~~
12 ~~inpatient general acute care services shall be uniformly~~
13 ~~increased so that base claims projected reimbursement is~~
14 ~~increased by an amount equal to the funds allocated in~~
15 ~~paragraph (2) of subsection (b) of Section 5A-12.6, less~~
16 ~~the amount allocated under paragraphs (8) and (9) of this~~
17 ~~subsection and paragraphs (3) and (4) of subsection (b)~~
18 ~~multiplied by 40%. Beginning July 1, 2022, the~~
19 ~~statewide standardized amount for inpatient general acute~~
20 ~~care services shall be uniformly increased so that base~~
21 ~~claims projected reimbursement is increased by an amount~~
22 ~~equal to the funds allocated in paragraph (3) of subsection~~
23 ~~(b) of Section 5A-12.6, less the amount allocated under~~
24 ~~paragraphs (8) and (9) of this subsection and paragraphs~~
25 ~~(3) and (4) of subsection (b) multiplied by 40%. Beginning~~
26 ~~July 1, 2023 the statewide standardized amount for~~

1 ~~inpatient general acute care services shall be uniformly~~
2 ~~increased so that base claims projected reimbursement is~~
3 ~~increased by an amount equal to the funds allocated in~~
4 ~~paragraph (4) of subsection (b) of Section 5A-12.6, less~~
5 ~~the amount allocated under paragraphs (8) and (9) of this~~
6 ~~subsection and paragraphs (3) and (4) of subsection (b)~~
7 ~~multiplied by 40%.~~

8 (11) Beginning July 1, 2018, the reimbursement for
9 inpatient rehabilitation services shall be increased by
10 the addition of a \$96 per day add-on.

11 ~~Beginning July 1, 2020, the reimbursement for~~
12 ~~inpatient rehabilitation services shall be uniformly~~
13 ~~increased so that the \$96 per day add on is increased by an~~
14 ~~amount equal to the funds allocated in paragraph (2) of~~
15 ~~subsection (b) of Section 5A-12.6, less the amount~~
16 ~~allocated under paragraphs (8) and (9) of this subsection~~
17 ~~and paragraphs (3) and (4) of subsection (b) multiplied by~~
18 ~~0.9%.~~

19 ~~Beginning July 1, 2022, the reimbursement for~~
20 ~~inpatient rehabilitation services shall be uniformly~~
21 ~~increased so that the \$96 per day add on as adjusted by the~~
22 ~~July 1, 2020 increase, is increased by an amount equal to~~
23 ~~the funds allocated in paragraph (3) of subsection (b) of~~
24 ~~Section 5A-12.6, less the amount allocated under~~
25 ~~paragraphs (8) and (9) of this subsection and paragraphs~~
26 ~~(3) and (4) of subsection (b) multiplied by 0.9%.~~

~~Beginning July 1, 2023, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the \$96 per day add on as adjusted by the July 1, 2022 increase, is increased by an amount equal to the funds allocated in paragraph (4) of subsection (b) of Section 5A 12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 0.9%.~~

(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 (EAPG) 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

1 calendar days prior to their effective date.

2 (B) The Department shall establish adjustments to
3 the statewide-standardized amounts for each Critical
4 Access Hospital, as designated by the Department of
5 Public Health in accordance with 42 CFR 485, Subpart F.
6 For outpatient services provided on or before June 30,
7 2018, the EAPG standardized amounts are determined
8 separately for each critical access hospital such that
9 simulated EAPG payments using outpatient base period
10 paid claim data plus payments under Section 5A-12.4 of
11 this Code net of the associated tax costs are equal to
12 the estimated costs of outpatient base period claims
13 data with a rate year cost inflation factor applied.

14 (3) In addition to the statewide-standardized amounts,
15 the Department shall develop adjusters to adjust the rate
16 of reimbursement for critical Medicaid hospital outpatient
17 providers or services, including outpatient high volume or
18 safety-net hospitals. Beginning July 1, 2018, the
19 outpatient high volume adjustor shall be increased to
20 increase annual expenditures associated with this adjustor
21 by \$79,200,000, based on the State Fiscal Year 2015 base
22 year data and this adjustor shall apply to public
23 hospitals, except for large public hospitals, as defined
24 under 89 Ill. Adm. Code 148.25(a).

25 (4) Beginning July 1, 2018, in addition to the
26 statewide standardized amounts, the Department shall make

1 an add-on payment for outpatient expensive devices and
2 drugs. This add-on payment shall at least apply to claim
3 lines that: (i) are assigned with one of the following
4 EAPGs: 490, 1001 to 1020, and coded with one of the
5 following revenue codes: 0274 to 0276, 0278; or (ii) are
6 assigned with one of the following EAPGs: 430 to 441, 443,
7 444, 460 to 465, 495, 496, 1090. The add-on payment shall
8 be calculated as follows: the claim line's covered charges
9 multiplied by the hospital's total acute cost to charge
10 ratio, less the claim line's EAPG payment plus \$1,000,
11 multiplied by 0.8.

12 (5) Beginning July 1, 2018, the statewide-standardized
13 amounts for outpatient services shall be increased by a
14 uniform percentage so that base claims projected
15 reimbursement is increased by an amount equal to no less
16 than the funds allocated in paragraph (1) of subsection (b)
17 of Section 5A-12.6, less the amount allocated under
18 paragraphs (8) and (9) of subsection (a) and paragraphs (3)
19 and (4) of this subsection multiplied by 46%. ~~Beginning~~
20 ~~July 1, 2020, the statewide-standardized amounts for~~
21 ~~outpatient services shall be increased by a uniform~~
22 ~~percentage so that base claims projected reimbursement is~~
23 ~~increased by an amount equal to no less than the funds~~
24 ~~allocated in paragraph (2) of subsection (b) of Section~~
25 ~~5A-12.6, less the amount allocated under paragraphs (8) and~~
26 ~~(9) of subsection (a) and paragraphs (3) and (4) of this~~

1 ~~subsection multiplied by 46%. Beginning July 1, 2022, the~~
2 ~~statewide standardized amounts for outpatient services~~
3 ~~shall be increased by a uniform percentage so that base~~
4 ~~claims projected reimbursement is increased by an amount~~
5 ~~equal to the funds allocated in paragraph (3) of subsection~~
6 ~~(b) of Section 5A 12.6, less the amount allocated under~~
7 ~~paragraphs (8) and (9) of subsection (a) and paragraphs (3)~~
8 ~~and (4) of this subsection multiplied by 46%. Beginning~~
9 ~~July 1, 2023, the statewide standardized amounts for~~
10 ~~outpatient services shall be increased by a uniform~~
11 ~~percentage so that base claims projected reimbursement is~~
12 ~~increased by an amount equal to no less than the funds~~
13 ~~allocated in paragraph (4) of subsection (b) of Section~~
14 ~~5A 12.6, less the amount allocated under paragraphs (8) and~~
15 ~~(9) of subsection (a) and paragraphs (3) and (4) of this~~
16 ~~subsection multiplied by 46%.~~

17 (6) Effective for dates of service on or after July 1,
18 2018, the Department shall establish adjustments to the
19 statewide-standardized amounts for each Critical Access
20 Hospital, as designated by the Department of Public Health
21 in accordance with 42 CFR 485, Subpart F, such that each
22 Critical Access Hospital's standardized amount for
23 outpatient services shall be increased by the applicable
24 uniform percentage determined pursuant to paragraph (5) of
25 this subsection. It is the intent of the General Assembly
26 that the adjustments required under this paragraph (6) by

1 Public Act 100-1181 ~~this amendatory Act of the 100th~~
2 ~~General Assembly~~ shall be applied retroactively to claims
3 for dates of service provided on or after July 1, 2018.

4 (7) Effective for dates of service on or after March 8,
5 2019 (the effective date of Public Act 100-1181) ~~this~~
6 ~~amendatory Act of the 100th General Assembly,~~ the
7 Department shall recalculate and implement an updated
8 statewide-standardized amount for outpatient services
9 provided by hospitals that are not Critical Access
10 Hospitals to reflect the applicable uniform percentage
11 determined pursuant to paragraph (5).

12 (1) Any recalculation to the
13 statewide-standardized amounts for outpatient services
14 provided by hospitals that are not Critical Access
15 Hospitals shall be the amount necessary to achieve the
16 increase in the statewide-standardized amounts for
17 outpatient services increased by a uniform percentage,
18 so that base claims projected reimbursement is
19 increased by an amount equal to no less than the funds
20 allocated in paragraph (1) of subsection (b) of Section
21 5A-12.6, less the amount allocated under paragraphs
22 (8) and (9) of subsection (a) and paragraphs (3) and
23 (4) of this subsection, for all hospitals that are not
24 Critical Access Hospitals, multiplied by 46%.

25 (2) It is the intent of the General Assembly that
26 the recalculations required under this paragraph (7)

1 by Public Act 100-1181 ~~this amendatory Act of the 100th~~
2 ~~General Assembly~~ shall be applied prospectively to
3 claims for dates of service provided on or after March
4 8, 2019 (the effective date of Public Act 100-1181)
5 ~~this amendatory Act of the 100th General Assembly~~ and
6 that no recoupment or repayment by the Department or an
7 MCO of payments attributable to recalculation under
8 this paragraph (7), issued to the hospital for dates of
9 service on or after July 1, 2018 and before March 8,
10 2019 (the effective date of Public Act 100-1181) ~~this~~
11 ~~amendatory Act of the 100th General Assembly~~, shall be
12 permitted.

13 (8) The Department shall ensure that all necessary
14 adjustments to the managed care organization capitation
15 base rates necessitated by the adjustments under
16 subparagraph (6) or (7) of this subsection are completed
17 and applied retroactively in accordance with Section
18 5-30.8 of this Code within 90 days of March 8, 2019 (the
19 effective date of Public Act 100-1181) ~~this amendatory Act~~
20 ~~of the 100th General Assembly~~.

21 (9) Within 60 days after federal approval of the change
22 made to the assessment in Section 5A-2 by this amendatory
23 Act of the 101st General Assembly, the Department shall
24 incorporate into the EAPG system for outpatient services
25 those services performed by hospitals currently billed
26 through the Non-Institutional Provider billing system.

1 (c) In consultation with the hospital community, the
2 Department is authorized to replace 89 Ill. Admin. Code 152.150
3 as published in 38 Ill. Reg. 4980 through 4986 within 12 months
4 of June 16, 2014 (the effective date of Public Act 98-651). If
5 the Department does not replace these rules within 12 months of
6 June 16, 2014 (the effective date of Public Act 98-651), the
7 rules in effect for 152.150 as published in 38 Ill. Reg. 4980
8 through 4986 shall remain in effect until modified by rule by
9 the Department. Nothing in this subsection shall be construed
10 to mandate that the Department file a replacement rule.

11 (d) Transition period. There shall be a transition period
12 to the reimbursement systems authorized under this Section that
13 shall begin on the effective date of these systems and continue
14 until June 30, 2018, unless extended by rule by the Department.
15 To help provide an orderly and predictable transition to the
16 new reimbursement systems and to preserve and enhance access to
17 the hospital services during this transition, the Department
18 shall allocate a transitional hospital access pool of at least
19 \$290,000,000 annually so that transitional hospital access
20 payments are made to hospitals.

21 (1) After the transition period, the Department may
22 begin incorporating the transitional hospital access pool
23 into the base rate structure; however, the transitional
24 hospital access payments in effect on June 30, 2018 shall
25 continue to be paid, if continued under Section 5A-16.

26 (2) After the transition period, if the Department

1 reduces payments from the transitional hospital access
2 pool, it shall increase base rates, develop new adjustors,
3 adjust current adjustors, develop new hospital access
4 payments based on updated information, or any combination
5 thereof by an amount equal to the decreases proposed in the
6 transitional hospital access pool payments, ensuring that
7 the entire transitional hospital access pool amount shall
8 continue to be used for hospital payments.

9 (d-5) Hospital and health care transformation program. The
10 Department, ~~in conjunction with the Hospital Transformation~~
11 ~~Review Committee created under subsection (d-5)~~, shall develop
12 a hospital and health care transformation program to provide
13 financial assistance to hospitals in transforming their
14 services and care models to better align with the needs of the
15 communities they serve. The payments authorized in this Section
16 shall be subject to approval by the federal government.

17 (1) Phase 1. In State fiscal years 2019 through 2020,
18 the Department shall allocate funds from the transitional
19 access hospital pool to create a hospital transformation
20 pool of at least \$262,906,870 annually and make hospital
21 transformation payments to hospitals. Subject to Section
22 5A-16, in State fiscal years 2019 and 2020, an Illinois
23 hospital that received either a transitional hospital
24 access payment under subsection (d) or a supplemental
25 payment under subsection (f) of this Section in State
26 fiscal year 2018, shall receive a hospital transformation

1 payment as follows:

2 (A) If the hospital's Rate Year 2017 Medicaid
3 inpatient utilization rate is equal to or greater than
4 45%, the hospital transformation payment shall be
5 equal to 100% of the sum of its transitional hospital
6 access payment authorized under subsection (d) and any
7 supplemental payment authorized under subsection (f).

8 (B) If the hospital's Rate Year 2017 Medicaid
9 inpatient utilization rate is equal to or greater than
10 25% but less than 45%, the hospital transformation
11 payment shall be equal to 75% of the sum of its
12 transitional hospital access payment authorized under
13 subsection (d) and any supplemental payment authorized
14 under subsection (f).

15 (C) If the hospital's Rate Year 2017 Medicaid
16 inpatient utilization rate is less than 25%, the
17 hospital transformation payment shall be equal to 50%
18 of the sum of its transitional hospital access payment
19 authorized under subsection (d) and any supplemental
20 payment authorized under subsection (f).

21 (2) Phase 2.

22 (A) The funding amount from phase one shall be
23 incorporated into directed payment and pass-through
24 payment methodologies described in Section 5A-12.7.
25 ~~During State fiscal years 2021 and 2022, the Department~~
26 ~~shall allocate funds from the transitional access~~

1 ~~hospital pool to create a hospital transformation pool~~
2 ~~annually and make hospital transformation payments to~~
3 ~~hospitals participating in the transformation program.~~
4 ~~Any hospital may seek transformation funding in Phase~~
5 ~~2. Any hospital that seeks transformation funding in~~
6 ~~Phase 2 to update or repurpose the hospital's physical~~
7 ~~structure to transition to a new delivery model, must~~
8 ~~submit to the Department in writing a transformation~~
9 ~~plan, based on the Department's guidelines, that~~
10 ~~describes the desired delivery model with projections~~
11 ~~of patient volumes by service lines and projected~~
12 ~~revenues, expenses, and net income that correspond to~~
13 ~~the new delivery model. In Phase 2, subject to the~~
14 ~~approval of rules, the Department may use the hospital~~
15 ~~transformation pool to increase base rates, develop~~
16 ~~new adjustors, adjust current adjustors, or develop~~
17 ~~new access payments in order to support and incentivize~~
18 ~~hospitals to pursue such transformation. In developing~~
19 ~~such methodologies, the Department shall ensure that~~
20 ~~the entire hospital transformation pool continues to~~
21 ~~be expended to ensure access to hospital services or to~~
22 ~~support organizations that had received hospital~~
23 ~~transformation payments under this Section.~~

24 (B) Whereas there are communities in Illinois that
25 suffer from significant health care disparities
26 aggravated by social determinants of health and a lack

1 of sufficiently allocated healthcare resources,
2 particularly community-based services and preventive
3 care, there is established a new hospital and health
4 care transformation program, which shall be supported
5 by a transformation funding pool. An application for
6 funding from the hospital and health care
7 transformation program may incorporate the campus of a
8 hospital closed after January 1, 2018 or a hospital
9 that has provided notice of its intent to close
10 pursuant to Section 8.7 of the Illinois Health
11 Facilities Planning Act. During State Fiscal Years
12 2021 through 2023, the hospital and health care
13 transformation program shall be supported by an annual
14 transformation funding pool of at least \$150,000,000
15 to be allocated during the specified fiscal years for
16 the purpose of facilitating hospital and health care
17 transformation. The Department shall not allocate
18 funds associated with the hospital and health care
19 transformation pool as established in this
20 subparagraph until the General Assembly has
21 established in law or resolution, further criteria for
22 dispersal or allocation of those funds after the
23 effective date of this amendatory Act of 101st General
24 Assembly.

25 ~~(A) Any hospital participating in the hospital~~
26 ~~transformation program shall provide an opportunity~~

1 ~~for public input by local community groups, hospital~~
2 ~~workers, and healthcare professionals and assist in~~
3 ~~facilitating discussions about any transformations or~~
4 ~~changes to the hospital.~~

5 (C) ~~(B)~~ As provided in paragraph (9) of Section 3
6 of the Illinois Health Facilities Planning Act, any
7 hospital participating in the transformation program
8 may be excluded from the requirements of the Illinois
9 Health Facilities Planning Act for those projects
10 related to the hospital's transformation. To be
11 eligible, the hospital must submit to the Health
12 Facilities and Services Review Board approval from
13 ~~certification from~~ the Department, ~~approved by the~~
14 ~~Hospital Transformation Review Committee,~~ that the
15 project is a part of the hospital's transformation.

16 (D) ~~(C)~~ As provided in subsection (a-20) of Section
17 32.5 of the Emergency Medical Services (EMS) Systems
18 Act, a hospital that received hospital transformation
19 payments under this Section may convert to a
20 freestanding emergency center. To be eligible for such
21 a conversion, the hospital must submit to the
22 Department of Public Health approval ~~certification~~
23 ~~from the Department, approved by the Hospital~~
24 ~~Transformation Review Committee,~~ that the project is a
25 part of the hospital's transformation.

26 (3) (Blank). ~~By April 1, 2019 March 12, 2018 (Public~~

~~Act 100-581) the Department, in conjunction with the Hospital Transformation Review Committee, shall develop and file as an administrative rule with the Secretary of State the goals, objectives, policies, standards, payment models, or criteria to be applied in Phase 2 of the program to allocate the hospital transformation funds. The goals, objectives, and policies to be considered may include, but are not limited to, achieving unmet needs of a community that a hospital serves such as behavioral health services, outpatient services, or drug rehabilitation services; attaining certain quality or patient safety benchmarks for health care services; or improving the coordination, effectiveness, and efficiency of care delivery. Notwithstanding any other provision of law, any rule adopted in accordance with this subsection (d-5) may be submitted to the Joint Committee on Administrative Rules for approval only if the rule has first been approved by 9 of the 14 members of the Hospital Transformation Review Committee.~~

(4) Hospital Transformation Review Committee. There is created the Hospital Transformation Review Committee. The Committee shall consist of 14 members. No later than 30 days after March 12, 2018 (the effective date of Public Act 100-581), the 4 legislative leaders shall each appoint 3 members; the Governor shall appoint the Director of Healthcare and Family Services, or his or her designee, as

1 a member; and the Director of Healthcare and Family
2 Services shall appoint one member. Any vacancy shall be
3 filled by the applicable appointing authority within 15
4 calendar days. The members of the Committee shall select a
5 Chair and a Vice-Chair from among its members, provided
6 that the Chair and Vice-Chair cannot be appointed by the
7 same appointing authority and must be from different
8 political parties. The Chair shall have the authority to
9 establish a meeting schedule and convene meetings of the
10 Committee, and the Vice-Chair shall have the authority to
11 convene meetings in the absence of the Chair. The Committee
12 may establish its own rules with respect to meeting
13 schedule, notice of meetings, and the disclosure of
14 documents; however, the Committee shall not have the power
15 to subpoena individuals or documents and any rules must be
16 approved by 9 of the 14 members. The Committee shall
17 perform the functions described in this Section and advise
18 and consult with the Director in the administration of this
19 Section. In addition to reviewing and approving the
20 policies, procedures, and rules for the hospital and health
21 care transformation program, the Committee shall consider
22 and make recommendations related to qualifying criteria
23 and payment methodologies related to safety-net hospitals
24 and children's hospitals. Members of the Committee
25 appointed by the legislative leaders shall be subject to
26 the jurisdiction of the Legislative Ethics Commission, not

1 the Executive Ethics Commission, and all requests under the
2 Freedom of Information Act shall be directed to the
3 applicable Freedom of Information officer for the General
4 Assembly. The Department shall provide operational support
5 to the Committee as necessary. The Committee is dissolved
6 on April 1, 2019.

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

14 (f) Continuation of supplemental payments. Any
15 supplemental payments authorized under Illinois Administrative
16 Code 148 effective January 1, 2014 and that continue during the
17 period of July 1, 2014 through December 31, 2014 shall remain
18 in effect as long as the assessment imposed by Section 5A-2
19 that is in effect on December 31, 2017 remains in effect.

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

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

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

14 (i) Except for subsections (g) and (h) of this Section, the
15 Department shall, pursuant to subsection (c) of Section 5-40 of
16 the Illinois Administrative Procedure Act, provide for
17 presentation at the June 2014 hearing of the Joint Committee on
18 Administrative Rules (JCAR) additional written notice to JCAR
19 of the following rules in order to commence the second notice
20 period for the following rules: rules published in the Illinois
21 Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559
22 (Medical Payment), 4628 (Specialized Health Care Delivery
23 Systems), 4640 (Hospital Services), 4932 (Diagnostic Related
24 Grouping (DRG) Prospective Payment System (PPS)), and 4977
25 (Hospital Reimbursement Changes), and published in the
26 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499

1 (Specialized Health Care Delivery Systems) and 6505 (Hospital
2 Services).

3 (j) Out-of-state hospitals. Beginning July 1, 2018, for
4 purposes of determining for State fiscal years 2019 and 2020
5 and subsequent fiscal years the hospitals eligible for the
6 payments authorized under subsections (a) and (b) of this
7 Section, the Department shall include out-of-state hospitals
8 that are designated a Level I pediatric trauma center or a
9 Level I trauma center by the Department of Public Health as of
10 December 1, 2017.

11 (k) The Department shall notify each hospital and managed
12 care organization, in writing, of the impact of the updates
13 under this Section at least 30 calendar days prior to their
14 effective date.

15 (Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19;
16 101-81, eff. 7-12-19; revised 7-29-19.)

17 Section 97. Severability. If any provision of this Act or
18 application thereof to any person or circumstance is held
19 invalid, such invalidity does not affect other provisions or
20 applications of this Act which can be given effect without the
21 invalid application or provision, and to this end the
22 provisions of this Act are declared to be severable.

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