AN ACT concerning public aid.

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

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

(5 ILCS 100/5-45.1 new)

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

This Section is repealed on January 1, 2026.

(5 ILCS 100/5-46.3 rep.)

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

Section 15. The Illinois Health Facilities Planning Act is

amended by changing Sections 3 and 8.7 as follows:

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

(Section scheduled to be repealed on December 31, 2029)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Federally-owned facilities.

(2) Facilities used solely for healing by prayer or

spiritual means.

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

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

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

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

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

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

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

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

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

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

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

combination thereof.

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

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

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

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

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

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

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

expenditure minimum.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(20 ILCS 3960/8.7)

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

Sec. 8.7. Application for permit for discontinuation of a

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

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

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

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

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

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

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

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

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

(30 ILCS 105/6z-81)

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

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

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

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

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

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

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

Provider Relief Fund.

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

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

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

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

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

(210 ILCS 50/32.5)

Sec. 32.5. Freestanding Emergency Center.

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

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

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

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

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

(B) equipment standards; and

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

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

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

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

(7) (blank);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The Department shall:

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

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

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

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

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

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

(305 ILCS 5/5-5.05c new)

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

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

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

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

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

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

(3) meets one of the following:

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

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

(b) Definitions. As used in this Section:

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

(2) "MIUR" means Medicaid Inpatient Utilization Rate

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

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

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

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

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

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

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

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

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

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

Sec. 5A-2. Assessment.

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

Procedure Act, be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, or as provided in Section 5A-16, in addition to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

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

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

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

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

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

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

(b) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

described in subparagraph (B).

(D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5A-8. Hospital Provider Fund.

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

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

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

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

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

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

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

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

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

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

General Revenue Fund ..... $80,000,000.

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

(7.1) (Blank).

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

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

Healthcare Provider Relief Fund $100,000,000

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

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

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

Healthcare Provider Relief Fund $50,000,000

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

(7.11) (Blank).

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

Healthcare Provider Relief Fund $2,870,000

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

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

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

Healthcare ~~Health Care~~ Provider Relief Fund ..... $325,000,000.

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

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

2022, to the following designated funds:

Health and Human Services Medicaid Trust Fund $20,000,000

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

Healthcare Provider Relief Fund $365,000,000

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

Health and Human Services Medicaid Trust Fund $10,000,000

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

Healthcare Provider Relief Fund $182,500,000

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

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

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

(c) The Fund shall consist of the following:

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

by this Article.

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

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

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

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

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

(d) (Blank).

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

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

Sec. 5A-10. Applicability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-12.7 new)

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

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

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

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

(c) Graduate medical education.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

rules:

(A) Critical access hospitals.

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

(C) Long term acute care hospitals.

(D) Freestanding psychiatric hospitals.

(E) Freestanding rehabilitation hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

(4) Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definitions. As used in this subsection:

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

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

(C) "Case mix index" means a hospital specific calculation. For inpatient claims the case mix index is calculated each quarter by summing the relative weight of all inpatient Diagnosis-Related Group (DRG) claims for a category of service in the applicable Determination Quarter and dividing the sum by the number of sum total of all inpatient DRG admissions for the category of service for the associated claims. The case mix index for outpatient claims is calculated each quarter by summing the relative weight of all paid EAPGs in the applicable Determination Quarter and dividing the sum by the sum total of paid EAPGs for the associated claims.

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

(j) Pass-through payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-12.8 new)

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

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

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

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

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

(B) analysis of charity care by hospital;

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

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

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

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

(305 ILCS 5/5A-13)

Sec. 5A-13. Emergency rulemaking.

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-14)

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-17 new)

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

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

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

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

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

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

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

hospital provider sells or transfers the major part of any one or more of (i) the real property and improvements, (ii) the machinery and equipment, or (iii) the furniture or fixtures of any hospital that is subject to the provisions of this Section, the seller or transferor shall pay the Illinois Department the amount of any obligation due from it under this Section up to the date of the sale or transfer. If the seller or transferor fails to pay any amount due under this Section, the purchaser or transferee of such asset shall be liable for the amount of the obligation up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the obligation up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Illinois Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Illinois Department showing that no amount is due from the seller or transferor under this Section.

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

(305 ILCS 5/12-4.105)

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

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

(305 ILCS 5/14-12)

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

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

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

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

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

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

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

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

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

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

(7.5) <u>(Blank).</u> ~~Beginning July 1, 2020, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (2) 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 13%. Beginning July 1, 2022, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) 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 13%. Beginning July 1, 2024, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement 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 13%.~~

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

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

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

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (1) 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 40%. ~~Beginning July 1, 2020, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (2) 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 40%. Beginning July 1, 2022, the statewide standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) 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 40%. Beginning July 1, 2023 the statewide standardized amount for~~

~~inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement 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 40%.~~

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

~~Beginning July 1, 2020, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on is increased by an amount equal to the funds allocated in paragraph (2) 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%.~~

~~Beginning July 1, 2022, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on as adjusted by the July 1, 2020 increase, is increased by an amount equal to the funds allocated in paragraph (3) 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%.~~

~~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

calendar days prior to their effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) After the transition period, if the Department

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

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

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

payment as follows:

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

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

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

(2) Phase 2.

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

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

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

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

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

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

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

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

(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

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

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

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

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

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

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

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

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

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

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

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

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

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

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