



## 101ST GENERAL ASSEMBLY

### State of Illinois

2019 and 2020

**HB4543**

Introduced 2/5/2020, by Rep. Emanuel Chris Welch - Camille Y. Lilly - LaToya Greenwood - Frances Ann Hurley

#### SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Public Aid Code. Provides that for State Fiscal Years 2021 through 2024, an annual assessment on inpatient and outpatient services is imposed on each hospital provider, subject to other specified provisions. Contains provisions concerning a hospital's non-Medicaid gross revenue for State Fiscal Years 2021 and 2022. Contains provisions concerning the assignment of a pool allocation percentage for certain hospitals designated as a Level II trauma center; increased capitation payments to managed care organizations; the extension of certain assessments to July 1, 2022 (rather than July 1, 2020); reimbursements for inpatient general acute care services to non-publicly owned safety net hospitals, non-publicly owned critical access hospitals, hospital providers in high-need communities, and other facilities; the allocation of funds from the transitional access hospital pool; administrative rules for data collection and payment from the health disparities pay-for-collection pool; and other matters. Amends the Illinois Administrative Procedure Act. Provides that the Department of Healthcare and Family Services shall have emergency rulemaking authority to implement the provisions of the amendatory Act concerning assessments. Amends the Emergency Medical Services (EMS) Systems Act. Removes provisions requiring the Department of Public Health to issue a Freestanding Emergency Center license to a facility that has discontinued inpatient hospital services and meets other requirements. Effective immediately.

LRB101 19021 KTG 68481 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 1. Legislative intent. The General Assembly finds  
5 that, in order to improve equitable access to hospital services  
6 for all Illinoisans, the hospital provider assessment and  
7 associated payments to hospitals from the Hospital Provider  
8 Fund must be reoriented toward the support of hospitals that  
9 are located in areas with the greatest health needs and most  
10 adversely affected by health disparities.

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

13 (5 ILCS 100/5-45.1 new)

14 Sec. 5-45.1. Emergency rulemaking; Department of  
15 Healthcare and Family Services. To provide for the expeditious  
16 and timely implementation of changes made by this amendatory  
17 Act of the 101st General Assembly to Sections 5A-2, 5A-12.6,  
18 5A-14, and 14-12 of the Illinois Public Aid Code, emergency  
19 rules may be adopted in accordance with Section 5-45 by the  
20 Department of Healthcare and Family Services. The adoption of  
21 emergency rules authorized by Section 5-45 and this Section is  
22 deemed to be necessary for the public interest, safety, and

1 welfare. This Section is repealed on January 1, 2026.

2 Section 10. The Emergency Medical Services (EMS) Systems  
3 Act is amended by changing Section 32.5 as follows:

4 (210 ILCS 50/32.5)

5 Sec. 32.5. Freestanding Emergency Center.

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

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

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

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

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

23 (B) equipment standards; and

24 (C) the number and qualifications of emergency

1 medical personnel and other staff, which must include  
2 at least one board certified emergency physician  
3 present at the FEC 24 hours per day.

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

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

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

17 (7) (blank);

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

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

25 (10) reports to the Department any patient transfers  
26 from the FEC to a hospital within 48 hours of the transfer

1 plus any other data determined to be relevant by the  
2 Department;

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

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

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

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

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

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

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

25 (a-5) Notwithstanding any other provision of this Section,  
26 the Department may issue an annual FEC license to a facility

1 that is located in a county that does not have a licensed  
2 general acute care hospital if the facility's application for a  
3 permit from the Illinois Health Facilities Planning Board has  
4 been deemed complete by the Department of Public Health by  
5 January 1, 2014 and if the facility complies with the  
6 requirements set forth in paragraphs (1) through (17) of  
7 subsection (a).

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

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

25 (a-20) (Blank). ~~Notwithstanding any other provision of~~  
26 ~~this Section, the Department shall issue an annual FEC license~~

1 ~~to a facility if:~~

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

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

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

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

22 (b) The Department shall:

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

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

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

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

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

17       Section 15. The Illinois Public Aid Code is amended by  
18 changing Sections 5A-2, 5A-12.6, 5A-13, 5A-14, and 14-12 as  
19 follows:

20           (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

22       Sec. 5A-2. Assessment.

23           (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal  
24 years 2009 through 2018, or as long as continued under Section



1 5A-16, an annual assessment on inpatient services is imposed on  
2 each hospital provider in an amount equal to \$218.38 multiplied  
3 by the difference of the hospital's occupied bed days less the  
4 hospital's Medicare bed days, provided, however, that the  
5 amount of \$218.38 shall be increased by a uniform percentage to  
6 generate an amount equal to 75% of the State share of the  
7 payments authorized under Section 5A-12.5, with such increase  
8 only taking effect upon the date that a State share for such  
9 payments is required under federal law. For the period of April  
10 through June 2015, the amount of \$218.38 used to calculate the  
11 assessment under this paragraph shall, by emergency rule under  
12 subsection (s) of Section 5-45 of the Illinois Administrative  
13 Procedure Act, be increased by a uniform percentage to generate  
14 \$20,250,000 in the aggregate for that period from all hospitals  
15 subject to the annual assessment under this paragraph.

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

24 For State fiscal years 2009 through 2018, or as provided in  
25 Section 5A-16, a hospital's occupied bed days and Medicare bed  
26 days shall be determined using the most recent data available

1 from each hospital's 2005 Medicare cost report as contained in  
2 the Healthcare Cost Report Information System file, for the  
3 quarter ending on December 31, 2006, without regard to any  
4 subsequent adjustments or changes to such data. If a hospital's  
5 2005 Medicare cost report is not contained in the Healthcare  
6 Cost Report Information System, then the Illinois Department  
7 may obtain the hospital provider's occupied bed days and  
8 Medicare bed days from any source available, including, but not  
9 limited to, records maintained by the hospital provider, which  
10 may be inspected at all times during business hours of the day  
11 by the Illinois Department or its duly authorized agents and  
12 employees.

13 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
14 fiscal years 2019 and 2020, an annual assessment on inpatient  
15 services is imposed on each hospital provider in an amount  
16 equal to \$197.19 multiplied by the difference of the hospital's  
17 occupied bed days less the hospital's Medicare bed days;  
18 however, for State fiscal year 2021, the amount of \$197.19  
19 shall be increased by a uniform percentage to generate an  
20 additional \$6,250,000 in the aggregate for that period from all  
21 hospitals subject to the annual assessment under this  
22 paragraph. For State fiscal years 2019 and 2020, a hospital's  
23 occupied bed days and Medicare bed days shall be determined  
24 using the most recent data available from each hospital's 2015  
25 Medicare cost report as contained in the Healthcare Cost Report  
26 Information System file, for the quarter ending on March 31,

1 2017, without regard to any subsequent adjustments or changes  
2 to such data. If a hospital's 2015 Medicare cost report is not  
3 contained in the Healthcare Cost Report Information System,  
4 then the Illinois Department may obtain the hospital provider's  
5 occupied bed days and Medicare bed days from any source  
6 available, including, but not limited to, records maintained by  
7 the hospital provider, which may be inspected at all times  
8 during business hours of the day by the Illinois Department or  
9 its duly authorized agents and employees. Notwithstanding any  
10 other provision in this Article, for a hospital provider that  
11 did not have a 2015 Medicare cost report, but paid an  
12 assessment in State fiscal year 2018 on the basis of  
13 hypothetical data, that assessment amount shall be used for  
14 State fiscal years 2019 and 2020; however, for State fiscal  
15 year 2021, the assessment amount shall be increased by the  
16 proportion that it represents of the total annual assessment  
17 that is generated from all hospitals in order to generate  
18 \$6,250,000 in the aggregate for that period from all hospitals  
19 subject to the annual assessment under this paragraph.

20 ~~Subject to Sections 5A-3 and 5A-10, for State fiscal years~~  
21 ~~2021 through 2024, an annual assessment on inpatient services~~  
22 ~~is imposed on each hospital provider in an amount equal to~~  
23 ~~\$197.19 multiplied by the difference of the hospital's occupied~~  
24 ~~bed days less the hospital's Medicare bed days, provided~~  
25 ~~however, that the amount of \$197.19 used to calculate the~~  
26 ~~assessment under this paragraph shall, by rule, be adjusted by~~

1 ~~a uniform percentage to generate the same total annual~~  
2 ~~assessment that was generated in State fiscal year 2020 from~~  
3 ~~all hospitals subject to the annual assessment under this~~  
4 ~~paragraph plus \$6,250,000. For State fiscal years 2021 and~~  
5 ~~2022, a hospital's occupied bed days and Medicare bed days~~  
6 ~~shall be determined using the most recent data available from~~  
7 ~~each hospital's 2017 Medicare cost report as contained in the~~  
8 ~~Healthcare Cost Report Information System file, for the quarter~~  
9 ~~ending on March 31, 2019, without regard to any subsequent~~  
10 ~~adjustments or changes to such data. For State fiscal years~~  
11 ~~2023 and 2024, a hospital's occupied bed days and Medicare bed~~  
12 ~~days shall be determined using the most recent data available~~  
13 ~~from each hospital's 2019 Medicare cost report as contained in~~  
14 ~~the Healthcare Cost Report Information System file, for the~~  
15 ~~quarter ending on March 31, 2021, without regard to any~~  
16 ~~subsequent adjustments or changes to such data.~~

17 (b) (Blank).

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

1 authorized under Section 5A-12.5, with such increase only  
2 taking effect upon the date that a State share for such  
3 payments is required under federal law. For the period  
4 beginning June 10, 2012 through June 30, 2012, the annual  
5 assessment on outpatient services shall be prorated by  
6 multiplying the assessment amount by a fraction, the numerator  
7 of which is 21 days and the denominator of which is 365 days.  
8 For the period of April through June 2015, the amount of  
9 .008766 used to calculate the assessment under this paragraph  
10 shall, by emergency rule under subsection (s) of Section 5-45  
11 of the Illinois Administrative Procedure Act, be increased by a  
12 uniform percentage to generate \$6,750,000 in the aggregate for  
13 that period from all hospitals subject to the annual assessment  
14 under this paragraph.

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

22 For the portion of State fiscal year 2012, beginning June  
23 10, 2012 through June 30, 2012, and State fiscal years 2013  
24 through 2018, or as provided in Section 5A-16, a hospital's  
25 outpatient gross revenue shall be determined using the most  
26 recent data available from each hospital's 2009 Medicare cost

1 report as contained in the Healthcare Cost Report Information  
2 System file, for the quarter ending on June 30, 2011, without  
3 regard to any subsequent adjustments or changes to such data.  
4 If a hospital's 2009 Medicare cost report is not contained in  
5 the Healthcare Cost Report Information System, then the  
6 Department may obtain the hospital provider's outpatient gross  
7 revenue from any source available, including, but not limited  
8 to, records maintained by the hospital provider, which may be  
9 inspected at all times during business hours of the day by the  
10 Department or its duly authorized agents and employees.

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

1 Department may obtain the hospital provider's outpatient gross  
2 revenue from any source available, including, but not limited  
3 to, records maintained by the hospital provider, which may be  
4 inspected at all times during business hours of the day by the  
5 Department or its duly authorized agents and employees.  
6 Notwithstanding any other provision in this Article, for a  
7 hospital provider that did not have a 2015 Medicare cost  
8 report, but paid an assessment in State fiscal year 2018 on the  
9 basis of hypothetical data, that assessment amount shall be  
10 used for State fiscal years 2019 and 2020; however, for State  
11 fiscal year 2021, the assessment amount shall be increased by  
12 the proportion that it represents of the total annual  
13 assessment that is generated from all hospitals in order to  
14 generate \$6,250,000 in the aggregate for that period from all  
15 hospitals subject to the annual assessment under this  
16 paragraph.

17 ~~Subject to Sections 5A 3 and 5A 10, for State fiscal years~~  
18 ~~2021 through 2024, an annual assessment on outpatient services~~  
19 ~~is imposed on each hospital provider in an amount equal to~~  
20 ~~.01358 multiplied by the hospital's outpatient gross revenue,~~  
21 ~~provided however, that the amount of .01358 used to calculate~~  
22 ~~the assessment under this paragraph shall, by rule, be adjusted~~  
23 ~~by a uniform percentage to generate the same total annual~~  
24 ~~assessment that was generated in State fiscal year 2020 from~~  
25 ~~all hospitals subject to the annual assessment under this~~  
26 ~~paragraph plus \$6,250,000. For State fiscal years 2021 and~~

1 ~~2022, a hospital's outpatient gross revenue shall be determined~~  
2 ~~using the most recent data available from each hospital's 2017~~  
3 ~~Medicare cost report as contained in the Healthcare Cost Report~~  
4 ~~Information System file, for the quarter ending on March 31,~~  
5 ~~2019, without regard to any subsequent adjustments or changes~~  
6 ~~to such data. For State fiscal years 2023 and 2024, a~~  
7 ~~hospital's outpatient gross revenue shall be determined using~~  
8 ~~the most recent data available from each hospital's 2019~~  
9 ~~Medicare cost report as contained in the Healthcare Cost Report~~  
10 ~~Information System file, for the quarter ending on March 31,~~  
11 ~~2021, without regard to any subsequent adjustments or changes~~  
12 ~~to such data.~~

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

15 (A) For the period of July 1, 2016 through December 31,  
16 2016, the product of .19125 multiplied by the sum of the  
17 fee-for-service payments to hospitals as authorized under  
18 Section 5A-12.5 and the adjustments authorized under  
19 subsection (t) of Section 5A-12.2 to managed care  
20 organizations for hospital services due and payable in the  
21 month of April 2016 multiplied by 6.

22 (B) For the period of January 1, 2017 through June 30,  
23 2017, the product of .19125 multiplied by the sum of the  
24 fee-for-service payments to hospitals as authorized under  
25 Section 5A-12.5 and the adjustments authorized under  
26 subsection (t) of Section 5A-12.2 to managed care



1 organizations for hospital services due and payable in the  
2 month of October 2016 multiplied by 6, except that the  
3 amount calculated under this subparagraph (B) shall be  
4 adjusted, either positively or negatively, to account for  
5 the difference between the actual payments issued under  
6 Section 5A-12.5 for the period beginning July 1, 2016  
7 through December 31, 2016 and the estimated payments due  
8 and payable in the month of April 2016 multiplied by 6 as  
9 described in subparagraph (A).

10 (C) For the period of July 1, 2017 through December 31,  
11 2017, the product of .19125 multiplied by the sum of the  
12 fee-for-service payments to hospitals as authorized under  
13 Section 5A-12.5 and the adjustments authorized under  
14 subsection (t) of Section 5A-12.2 to managed care  
15 organizations for hospital services due and payable in the  
16 month of April 2017 multiplied by 6, except that the amount  
17 calculated under this subparagraph (C) shall be adjusted,  
18 either positively or negatively, to account for the  
19 difference between the actual payments issued under  
20 Section 5A-12.5 for the period beginning January 1, 2017  
21 through June 30, 2017 and the estimated payments due and  
22 payable in the month of October 2016 multiplied by 6 as  
23 described in subparagraph (B).

24 (D) For the period of January 1, 2018 through June 30,  
25 2018, the product of .19125 multiplied by the sum of the  
26 fee-for-service payments to hospitals as authorized under

1 Section 5A-12.5 and the adjustments authorized under  
2 subsection (t) of Section 5A-12.2 to managed care  
3 organizations for hospital services due and payable in the  
4 month of October 2017 multiplied by 6, except that:

5 (i) the amount calculated under this subparagraph

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

13 (ii) the amount calculated under this subparagraph

14 (D) shall be adjusted to include the product of .19125  
15 multiplied by the sum of the fee-for-service payments,  
16 if any, estimated to be paid to hospitals under  
17 subsection (b) of Section 5A-12.5.

18 (2) The Department shall complete and apply a final  
19 reconciliation of the ACA Assessment Adjustment prior to June  
20 30, 2018 to account for:

21 (A) any differences between the actual payments issued  
22 or scheduled to be issued prior to June 30, 2018 as  
23 authorized in Section 5A-12.5 for the period of January 1,  
24 2018 through June 30, 2018 and the estimated payments due  
25 and payable in the month of October 2017 multiplied by 6 as  
26 described in subparagraph (D); and

1           (B) any difference between the estimated  
2 fee-for-service payments under subsection (b) of Section  
3 5A-12.5 and the amount of such payments that are actually  
4 scheduled to be paid.

5           The Department shall notify hospitals of any additional  
6 amounts owed or reduction credits to be applied to the June  
7 2018 ACA Assessment Adjustment. This is to be considered the  
8 final reconciliation for the ACA Assessment Adjustment.

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

19           (4) The increases authorized under paragraph (2) of  
20 subsection (a) and paragraph (2) of subsection (b-5) shall be  
21 limited to the federally required State share of the total  
22 payments authorized under Section 5A-12.5 if the sum of such  
23 payments yields an annualized amount equal to or less than  
24 \$450,000,000, or if the adjustments authorized under  
25 subsection (t) of Section 5A-12.2 are found not to be  
26 actuarially sound; however, this limitation shall not apply to

1 the fee-for-service payments described in subsection (b) of  
2 Section 5A-12.5.

3 (c) (Blank).

4 (c-5)(1) Subject to Sections 5A-3 and 5A-10, for State  
5 Fiscal Years 2021 through 2024, an annual assessment on  
6 inpatient and outpatient services is imposed on each hospital  
7 provider. The assessment shall be as described in paragraph (2)  
8 of this subsection.

9 (2)(A) The "total assessment" shall be equal to the sum of  
10 the following 2 numbers:

11 (B) The assessment imposed on each hospital provider shall  
12 be equal to a rate multiplied by the sum of their non-Medicaid  
13 inpatient gross revenue and non-Medicaid outpatient gross  
14 revenue. The Department shall determine the rate so that it is  
15 uniform for all hospital providers subject to the assessment  
16 and the funds generated by the assessment are equivalent to the  
17 total assessment.

18 For State Fiscal Years 2021 and 2022, a hospital's  
19 non-Medicaid gross revenue shall be determined using the most  
20 recent data available from each hospital's 2017 Medicare cost  
21 report as contained in the Healthcare Cost Report Information  
22 System file, for the quarter ending on March 31, 2019, without  
23 regard to any subsequent adjustments or changes to such data.  
24 For State Fiscal Years 2023 and 2024, a hospital's non-Medicaid  
25 gross revenue shall be determined using the most recent data  
26 available from each hospital's 2019 Medicare cost report as

1 contained in the Healthcare Cost Report Information System  
2 file, for the quarter ending on March 31, 2021, without regard  
3 to any subsequent adjustments or changes to such data. If a  
4 hospital's Medicare cost report is not contained in the  
5 Healthcare Cost Report Information System or the hospital's  
6 Medicare cost report contains insufficient information to  
7 determine gross non-Medicaid inpatient or outpatient revenue,  
8 then the Department may obtain the hospital provider's gross  
9 non-Medicaid revenue from any source available, including, but  
10 not limited to, records maintained by the hospital provider,  
11 which may be inspected at all times during business hours of  
12 the day by the Department or its duly authorized agents and  
13 employees. The Department may also set any additional reporting  
14 requirements for Medicare cost reports as deemed necessary to  
15 determine non-Medicaid gross revenue inpatient and outpatient  
16 revenue for future fiscal years.

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

22 (e) Notwithstanding any other provision of this Section,  
23 any plan providing for an assessment on a hospital provider as  
24 a permissible tax under Title XIX of the federal Social  
25 Security Act and Medicaid-eligible payments to hospital  
26 providers from the revenues derived from that assessment shall

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

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

22 (305 ILCS 5/5A-12.6)

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

24 Sec. 5A-12.6. Continuation of hospital access payments on  
25 or after July 1, 2018.

1           (a) To preserve and improve access to hospital services,  
2 for hospital services rendered on or after July 1, 2018 the  
3 Department shall, except for hospitals described in subsection  
4 (b) of Section 5A-3, make payments to hospitals as set forth in  
5 this Section. Payments under this Section are not due and  
6 payable, however, until (i) the methodologies described in this  
7 Section are approved by the federal government in an  
8 appropriate State Plan amendment and (ii) the assessment  
9 imposed under this Article is determined to be a permissible  
10 tax under Title XIX of the Social Security Act. In determining  
11 the hospital access payments authorized under subsections (f)  
12 through (n) of this Section, unless otherwise specified, only  
13 Illinois hospitals shall be eligible for a payment and total  
14 Medicaid utilization statistics shall be used to determine the  
15 payment amount. In determining the hospital access payments  
16 authorized under subsection (d) and subsections (f) through (l)  
17 of this Section, if a hospital ceases to receive payments from  
18 the pool, the payments for all hospitals continuing to receive  
19 payments from such pool shall be uniformly adjusted to fully  
20 expend the aggregate amount of the pool, with such adjustment  
21 being effective on the first day of the second month following  
22 the date the hospital ceases to receive payments from such  
23 pool.

24           (b) Phase in of funds to claims-based payments and updates.  
25 To ensure access to hospital services, the Department may only  
26 use funds financed by the assessment authorized under Section

1 5A-2 to increase claims-based payment rates, including  
2 applicable policy add-on payments or adjusters, in accordance  
3 with this subsection. Starting in State Fiscal Year 2021, to ~~to~~  
4 increase the claims-based payment rates up to the amounts  
5 specified in this subsection, the hospital access payments  
6 authorized in paragraphs (3) through (5) of subsection (g),  
7 paragraph (3) of subsection (h), paragraph (2) of subsection  
8 (i), paragraph (1) of subsection (j), subsection (k), and  
9 subsection (n) of this Section shall be reduced to zero.  
10 Following this, the remaining hospital access payments  
11 authorized in subsection (d) and subsections (g) through (l) of  
12 this Section shall be uniformly reduced.

13 (1) For State fiscal years 2019 and 2020, up to  
14 \$635,000,000 of the total spending financed from the  
15 assessment authorized under Section 5A-2 that is intended  
16 to pay for hospital services and the hospital supplemental  
17 access payments authorized under subsections (d) and (f) of  
18 Section 14-12 for payment in State fiscal year 2018 may be  
19 used to increase claims-based hospital payment rates as  
20 specified under Section 14-12.

21 (2) For State fiscal years 2021 and 2022, up to  
22 \$1,696,000,000 ~~\$1,164,000,000~~ of the total spending  
23 financed from the assessment authorized under Section 5A-2  
24 that is intended to pay for hospital services and the  
25 hospital supplemental access payments authorized under  
26 subsections (d) and (f) of Section 14-12 for payment in



1 State Fiscal Year 2018 may be used to increase claims-based  
2 hospital payment rates as specified under Section 14-12.

3 (3) (Blank). ~~For State fiscal years 2023, up to~~  
4 ~~\$1,397,000,000 of the total spending financed from the~~  
5 ~~assessment authorized under Section 5A-2 that is intended~~  
6 ~~to pay for hospital services and the hospital supplemental~~  
7 ~~access payments authorized under subsections (d) and (f) of~~  
8 ~~Section 14-12 for payment in State Fiscal Year 2018 may be~~  
9 ~~used to increase claims based hospital payment rates as~~  
10 ~~specified under Section 14-12.~~

11 (4) (Blank). ~~For State fiscal years 2024, up to~~  
12 ~~\$1,663,000,000 of the total spending financed from the~~  
13 ~~assessment authorized under Section 5A-2 that is intended~~  
14 ~~to pay for hospital services and the hospital supplemental~~  
15 ~~access payments authorized under subsections (d) and (f) of~~  
16 ~~Section 14-12 for payment in State Fiscal Year 2018 may be~~  
17 ~~used to increase claims based hospital payment rates as~~  
18 ~~specified under Section 14-12.~~

19 (5) Beginning in State fiscal year 2021, and at least  
20 every 24 months thereafter, the Department shall, by rule,  
21 update the hospital access payments authorized under this  
22 Section to take into account the amount of funds being used  
23 to increase claims-based hospital payment rates under  
24 Section 14-12 and to apply the most recently available data  
25 and information, including data from the most recent base  
26 year and qualifying criteria which shall correlate to the

1 updated base year data, to determine a hospital's  
2 eligibility for each payment and the amount of the payment  
3 authorized under this Section. Any updates of the hospital  
4 access payment methodologies shall not result in any  
5 diminishment of the aggregate amount of hospital access  
6 payment expenditures, except for reductions attributable  
7 to the use of such funds to increase claims-based hospital  
8 payment rates as authorized by this Section. Nothing in  
9 this Section shall be construed as precluding variations in  
10 the amount of any individual hospital's access payments.  
11 The Department shall publish the proposed rules to update  
12 the hospital access payments at least 90 days before their  
13 proposed effective date. The proposed rules shall not be  
14 adopted using emergency rulemaking authority. The  
15 Department shall notify each hospital, in writing, of the  
16 impact of these updates on the hospital at least 30  
17 calendar days prior to their effective date.

18 (c) The hospital access payments authorized under  
19 subsections (d) through (n) of this Section shall be paid in 12  
20 equal installments on or before the seventh State business day  
21 of each month, except that no payment shall be due within 100  
22 days after the later of the date of notification of federal  
23 approval of the payment methodologies required under this  
24 Section or any waiver required under 42 CFR 433.68, at which  
25 time the sum of amounts required under this Section prior to  
26 the date of notification is due and payable. Payments under

1 this Section are not due and payable, however, until (i) the  
2 methodologies described in this Section are approved by the  
3 federal government in an appropriate State Plan amendment and  
4 (ii) the assessment imposed under this Article is determined to  
5 be a permissible tax under Title XIX of the Social Security  
6 Act. The Department may, when practicable, accelerate the  
7 schedule upon which payments authorized under this Section are  
8 made.

9 (d) Rate increase-based adjustment.

10 (1) From the funds financed by the assessment  
11 authorized under Section 5A-2, individual funding pools by  
12 category of service shall be established, for Inpatient  
13 General Acute Care services in the amount of \$268,051,572,  
14 Inpatient Rehab Care services in the amount of \$24,500,610,  
15 Inpatient Psychiatric Care service in the amount of  
16 \$94,617,812, and Outpatient Care Services in the amount of  
17 \$328,828,641.

18 (2) Each Illinois hospital and other hospitals  
19 authorized under this subsection, except for long-term  
20 acute care hospitals and public hospitals, shall be  
21 assigned a pool allocation percentage for each category of  
22 service that is equal to the ratio of the hospital's  
23 estimated FY2019 claims-based payments including all  
24 applicable FY2019 policy adjusters, multiplied by the  
25 applicable service credit factor for the hospital, divided  
26 by the total of the FY2019 claims-based payments including

1 all FY2019 policy adjusters for each category of service  
2 adjusted by each hospital's applicable service credit  
3 factor for all qualified hospitals. For each category of  
4 service, a hospital shall receive a supplemental payment  
5 equal to its pool allocation percentage multiplied by the  
6 total pool amount.

7 (3) Effective July 1, 2018, for purposes of determining  
8 for State fiscal years 2019 and 2020 the hospitals eligible  
9 for the payments authorized under this subsection, the  
10 Department shall include children's hospitals located in  
11 St. Louis that are designated a Level III perinatal center  
12 by the Department of Public Health and also designated a  
13 Level I pediatric trauma center by the Department of Public  
14 Health as of December 1, 2017.

15 (4) As used in this subsection, "service credit factor"  
16 is determined based on a hospital's Rate Year 2017 Medicaid  
17 inpatient utilization rate ("MIUR") rounded to the nearest  
18 whole percentage, as follows:

19 (A) Tier 1: A hospital with a MIUR equal to or  
20 greater than 60% shall have a service credit factor of  
21 200%.

22 (B) Tier 2: A hospital with a MIUR equal to or  
23 greater than 33% but less than 60% shall have a service  
24 credit factor of 100%.

25 (C) Tier 3: A hospital with a MIUR equal to or  
26 greater than 20% but less than 33% shall have a service

1 credit factor of 50%.

2 (D) Tier 4: A hospital with a MIUR less than 20%  
3 shall have a service credit factor of 10%.

4 (e) Graduate medical education.

5 (1) The calculation of graduate medical education  
6 payments shall be based on the hospital's Medicare cost  
7 report ending in Calendar Year 2015, as reported in  
8 Medicare cost reports released on October 19, 2016 with  
9 data through September 30, 2016. An Illinois hospital  
10 reporting intern and resident cost on its Medicare cost  
11 report shall be eligible for graduate medical education  
12 payments.

13 (2) Each hospital's annualized Medicaid Intern  
14 Resident Cost is calculated using annualized intern and  
15 resident total costs obtained from Worksheet B Part I,  
16 Column 21 and 22 the sum of Lines 30-43, 50-76, 90-93,  
17 96-98, and 105-112 multiplied by the percentage that the  
18 hospital's Medicaid days (Worksheet S3 Part I, Column 7,  
19 Lines 14 and 16-18) comprise of the hospital's total days  
20 (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).

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

1           (4) For each hospital, its annualized Medicaid Intern  
2           Resident Cost and its annualized Medicaid IME payment are  
3           summed and multiplied by 33% to determine the hospital's  
4           final graduate medical education payment.

5           (f) Alzheimer's treatment access payment. Each Illinois  
6           academic medical center or teaching hospital, as defined in  
7           Section 5-5e.2 of this Code, that is identified as the primary  
8           hospital affiliate of one of the Regional Alzheimer's Disease  
9           Assistance Centers, as designated by the Alzheimer's Disease  
10          Assistance Act and identified in the Department of Public  
11          Health's Alzheimer's Disease State Plan dated December 2016,  
12          shall be paid an Alzheimer's treatment access payment equal to  
13          the product of \$10,000,000 multiplied by a fraction, the  
14          numerator of which is the qualifying hospital's Fiscal Year  
15          2015 total admissions and the denominator of which is the  
16          Fiscal Year 2015 total admissions for all hospitals eligible  
17          for the payment.

18          (g) Safety-net hospital, private critical access hospital,  
19          and outpatient high volume access payment.

20          (1) Each safety-net hospital, as defined in Section  
21          5-5e.1 of this Code, for Rate Year 2017 that is not  
22          publicly owned shall be paid an outpatient high volume  
23          access payment equal to \$40,000,000 multiplied by a  
24          fraction, the numerator of which is the hospital's Fiscal  
25          Year 2015 outpatient services and the denominator of which  
26          is the Fiscal Year 2015 outpatient services for all

1 hospitals eligible under this paragraph for this payment.

2 (2) Each critical access hospital that is not publicly  
3 owned shall be paid an outpatient high volume access  
4 payment equal to \$55,000,000 multiplied by a fraction, the  
5 numerator of which is the hospital's Fiscal Year 2015  
6 outpatient services and the denominator of which is the  
7 Fiscal Year 2015 outpatient services for all hospitals  
8 eligible under this paragraph for this payment.

9 (3) Each tier 1 hospital that is not publicly owned  
10 shall be paid an outpatient high volume access payment  
11 equal to \$25,000,000 multiplied by a fraction, the  
12 numerator of which is the hospital's Fiscal Year 2015  
13 outpatient services and the denominator of which is the  
14 Fiscal Year 2015 outpatient services for all hospitals  
15 eligible under this paragraph for this payment. A tier 1  
16 outpatient high volume hospital means one of the following:  
17 (i) a non-publicly owned hospital, excluding a safety net  
18 hospital as defined in Section 5-5e.1 of this Code for Rate  
19 Year 2017, with total outpatient services, equal to or  
20 greater than the regional mean plus one standard deviation  
21 for all hospitals in the region but less than the mean plus  
22 1.5 standard deviation; (ii) an Illinois non-publicly  
23 owned hospital with total outpatient service units equal to  
24 or greater than the statewide mean plus one standard  
25 deviation; or (iii) a non-publicly owned safety net  
26 hospital as defined in Section 5-5e.1 of this Code for Rate

1 Year 2017, with total outpatient services, equal to or  
2 greater than the regional mean plus one standard deviation  
3 for all hospitals in the region.

4 (4) Each tier 2 hospital that is not publicly owned  
5 shall be paid an outpatient high volume access payment  
6 equal to \$25,000,000 multiplied by a fraction, the  
7 numerator of which is the hospital's Fiscal Year 2015  
8 outpatient services and the denominator of which is the  
9 Fiscal Year 2015 outpatient services for all hospitals  
10 eligible under this paragraph for this payment. A tier 2  
11 outpatient high volume hospital means a non-publicly owned  
12 hospital, excluding a safety-net hospital as defined in  
13 Section 5-5e.1 of this Code for Rate Year 2017, with total  
14 outpatient services equal to or greater than the regional  
15 mean plus 1.5 standard deviations for all hospitals in the  
16 region but less than the mean plus 2 standard deviations.

17 (5) Each tier 3 hospital that is not publicly owned  
18 shall be paid an outpatient high volume access payment  
19 equal to \$58,000,000 multiplied by a fraction, the  
20 numerator of which is the hospital's Fiscal Year 2015  
21 outpatient services and the denominator of which is the  
22 Fiscal Year 2015 outpatient services for all hospitals  
23 eligible under this paragraph for this payment. A tier 3  
24 outpatient high volume hospital means a non-publicly owned  
25 hospital, excluding a safety-net hospital as defined in  
26 Section 5-5e.1 of this Code for Rate Year 2017, with total



1 outpatient services equal to or greater than the regional  
2 mean plus 2 standard deviations for all hospitals in the  
3 region.

4 (h) Medicaid dependent or high volume hospital access  
5 payment.

6 (1) To qualify for a Medicaid dependent hospital access  
7 payment, a hospital shall meet one of the following  
8 criteria:

9 (A) Be a non-publicly owned general acute care  
10 hospital that is a safety-net hospital, as defined in  
11 Section 5-5e.1 of this Code, for Rate Year 2017.

12 (B) Be a pediatric hospital that is a safety net  
13 hospital, as defined in Section 5-5e.1 of this Code,  
14 for Rate Year 2017 and have a Medicaid inpatient  
15 utilization rate equal to or greater than 50%.

16 (C) Be a general acute care hospital with a  
17 Medicaid inpatient utilization rate equal to or  
18 greater than 50% in Rate Year 2017.

19 (2) The Medicaid dependent hospital access payment  
20 shall be determined as follows:

21 (A) Each tier 1 hospital shall be paid a Medicaid  
22 dependent hospital access payment equal to \$23,000,000  
23 multiplied by a fraction, the numerator of which is the  
24 hospital's Fiscal Year 2015 total days and the  
25 denominator of which is the Fiscal Year 2015 total days  
26 for all hospitals eligible under this subparagraph for

1           this payment. A tier 1 Medicaid dependent hospital  
2           means a qualifying hospital with a Rate Year 2017  
3           Medicaid inpatient utilization rate equal to or  
4           greater than the statewide mean but less than the  
5           statewide mean plus 0.5 standard deviation.

6           (B) Each tier 2 hospital shall be paid a Medicaid  
7           dependent hospital access payment equal to \$15,000,000  
8           multiplied by a fraction, the numerator of which is the  
9           hospital's Fiscal Year 2015 total days and the  
10          denominator of which is the Fiscal Year 2015 total days  
11          for all hospitals eligible under this subparagraph for  
12          this payment. A tier 2 Medicaid dependent hospital  
13          means a qualifying hospital with a Rate Year 2017  
14          Medicaid inpatient utilization rate equal to or  
15          greater than the statewide mean plus 0.5 standard  
16          deviations but less than the statewide mean plus one  
17          standard deviation.

18          (C) Each tier 3 hospital shall be paid a Medicaid  
19          dependent hospital access payment equal to \$15,000,000  
20          multiplied by a fraction, the numerator of which is the  
21          hospital's Fiscal Year 2015 total days and the  
22          denominator of which is the Fiscal Year 2015 total days  
23          for all hospitals eligible under this subparagraph for  
24          this payment. A tier 3 Medicaid dependent hospital  
25          means a qualifying hospital with a Rate Year 2017  
26          Medicaid inpatient utilization rate equal to or

1 greater than the statewide mean plus one standard  
2 deviation but less than the statewide mean plus 1.5  
3 standard deviations.

4 (D) Each tier 4 hospital shall be paid a Medicaid  
5 dependent hospital access payment equal to \$53,000,000  
6 multiplied by a fraction, the numerator of which is the  
7 hospital's Fiscal Year 2015 total days and the  
8 denominator of which is the Fiscal Year 2015 total days  
9 for all hospitals eligible under this subparagraph for  
10 this payment. A tier 4 Medicaid dependent hospital  
11 means a qualifying hospital with a Rate Year 2017  
12 Medicaid inpatient utilization rate equal to or  
13 greater than the statewide mean plus 1.5 standard  
14 deviations but less than the statewide mean plus 2  
15 standard deviations.

16 (E) Each tier 5 hospital shall be paid a Medicaid  
17 dependent hospital access payment equal to \$75,000,000  
18 multiplied by a fraction, the numerator of which is the  
19 hospital's Fiscal Year 2015 total days and the  
20 denominator of which is the Fiscal Year 2015 total days  
21 for all hospitals eligible under this subparagraph for  
22 this payment. A tier 5 Medicaid dependent hospital  
23 means a qualifying hospital with a Rate Year 2017  
24 Medicaid inpatient utilization rate equal to or  
25 greater than the statewide mean plus 2 standard  
26 deviations.

1           (3) Each Medicaid high volume hospital shall be paid a  
2 Medicaid high volume access payment equal to \$300,000,000  
3 multiplied by a fraction, the numerator of which is the  
4 hospital's Fiscal Year 2015 total admissions and the  
5 denominator of which is the Fiscal Year 2015 total  
6 admissions for all hospitals eligible under this paragraph  
7 for this payment. A Medicaid high volume hospital means the  
8 Illinois general acute care hospitals with the highest  
9 number of Fiscal Year 2015 total admissions that when  
10 ranked in descending order from the highest Fiscal Year  
11 2015 total admissions to the lowest Fiscal Year 2015 total  
12 admissions, in the aggregate, sum to at least 50% of the  
13 total admissions for all such hospitals in Fiscal Year  
14 2015; however, any hospital which has qualified as a  
15 Medicaid dependent hospital shall not also be considered a  
16 Medicaid high volume hospital.

17           (i) Perinatal care access payment.

18           (1) Each Illinois non-publicly owned hospital  
19 designated a Level II or II+ perinatal center by the  
20 Department of Public Health as of December 1, 2017 shall be  
21 assigned a pool allocation percentage equal to a fraction,  
22 the numerator of which is the hospital's Fiscal Year 2015  
23 total admissions multiplied by the hospital's Medicaid  
24 utilization factor and the denominator of which is the sum  
25 of Fiscal Year 2015 admissions multiplied by Medicaid  
26 utilization factor for all hospitals authorized for

1 payment under this paragraph. Each qualifying hospital  
2 will be paid an access payment equal to \$200,000,000  
3 multiplied by its pool allocation percentage. a fraction,  
4 the numerator of which is the hospital's Fiscal Year 2015  
5 total admissions and the denominator of which is the Fiscal  
6 Year 2015 total admissions for all hospitals eligible under  
7 this paragraph for this payment.

8 (2) Each Illinois non-publicly owned hospital  
9 designated a Level III perinatal center by the Department  
10 of Public Health as of December 1, 2017 shall be paid an  
11 access payment equal to \$100,000,000 multiplied by a  
12 fraction, the numerator of which is the hospital's Fiscal  
13 Year 2015 total admissions and the denominator of which is  
14 the Fiscal Year 2015 total admissions for all hospitals  
15 eligible under this paragraph for this payment.

16 (3) As used in this subsection, "Medicaid utilization  
17 factor" is equal to the square of the sum of 0.5 and the  
18 hospital's rate year 2017 Medicaid inpatient utilization  
19 rate.

20 (j) Trauma care access payment.

21 (1) Each Illinois non-publicly owned hospital  
22 designated a Level I trauma center by the Department of  
23 Public Health as of December 1, 2017 shall be paid an  
24 access payment equal to \$160,000,000 multiplied by a  
25 fraction, the numerator of which is the hospital's Fiscal  
26 Year 2015 total admissions and the denominator of which is

1 the Fiscal Year 2015 total admissions for all hospitals  
2 eligible under this paragraph for this payment.

3 (2) Each Illinois non-publicly owned hospital  
4 designated a Level II trauma center by the Department of  
5 Public Health as of December 1, 2017 shall be assigned a  
6 pool allocation percentage equal to a fraction, the  
7 numerator of which is the hospital's Fiscal Year 2015 total  
8 admissions multiplied by the hospital's Medicaid  
9 utilization factor and the denominator of which is the sum  
10 of Fiscal Year 2015 admissions multiplied by Medicaid  
11 utilization factor for all hospitals authorized for  
12 payment under this paragraph. Each qualifying hospital  
13 will be paid an access payment equal to \$200,000,000  
14 multiplied by its pool allocation percentage. a fraction,  
15 ~~the numerator of which is the hospital's Fiscal Year 2015~~  
16 ~~total admissions and the denominator of which is the Fiscal~~  
17 ~~Year 2015 total admissions for all hospitals eligible under~~  
18 ~~this paragraph for this payment.~~

19 (3) As used in this subsection, "Medicaid utilization  
20 factor" is equal to the square of the sum of 0.5 and the  
21 hospital's rate year 2017 Medicaid inpatient utilization  
22 rate.

23 (k) Perinatal and trauma center access payment.

24 (1) Each Illinois non-publicly owned hospital  
25 designated a Level III perinatal center and a Level I or II  
26 trauma center by the Department of Public Health as of

1 December 1, 2017, and that has a Rate Year 2017 Medicaid  
2 inpatient utilization rate equal to or greater than 20% and  
3 a calendar year 2015 occupancy ratio equal to or greater  
4 than 50%, shall be paid an access payment equal to  
5 \$160,000,000 multiplied by a fraction, the numerator of  
6 which is the hospital's Fiscal Year 2015 total admissions  
7 and the denominator of which is the Fiscal Year 2015 total  
8 admissions for all hospitals eligible under this paragraph  
9 for this payment.

10 (2) Each Illinois non-publicly owned hospital  
11 designated a Level II or II+ perinatal center and a Level I  
12 or II trauma center by the Department of Public Health as  
13 of December 1, 2017, and that has a Rate Year 2017 Medicaid  
14 inpatient utilization rate equal to or greater than 20% and  
15 a calendar year 2015 occupancy ratio equal to or greater  
16 than 50%, shall be paid an access payment equal to  
17 \$200,000,000 multiplied by a fraction, the numerator of  
18 which is the hospital's Fiscal Year 2015 total admissions  
19 and the denominator of which is the Fiscal Year 2015 total  
20 admissions for all hospitals eligible under this paragraph  
21 for this payment.

22 (1) Long-term acute care access payment. Each Illinois  
23 non-publicly owned long-term acute care hospital that has a  
24 Rate Year 2017 Medicaid inpatient utilization rate equal to or  
25 greater than 25% and a calendar year 2015 occupancy ratio equal  
26 to or greater than 60% shall be paid an access payment equal to

1 \$19,000,000 multiplied by a fraction, the numerator of which is  
2 the hospital's Fiscal Year 2015 general acute care admissions  
3 and the denominator of which is the Fiscal Year 2015 general  
4 acute care admissions for all hospitals eligible under this  
5 subsection for this payment.

6 (m) Small public hospital access payment.

7 (1) As used in this subsection, "small public hospital"  
8 means any Illinois publicly owned hospital which is not a  
9 "large public hospital" as described in 89 Ill. Adm. Code  
10 148.25(a).

11 (2) Each small public hospital shall be paid an  
12 inpatient access payment equal to \$2,825,000 multiplied by  
13 a fraction, the numerator of which is the hospital's Fiscal  
14 Year 2015 total days and the denominator of which is the  
15 Fiscal Year 2015 total days for all hospitals under this  
16 paragraph for this payment.

17 (3) Each small public hospital shall be paid an  
18 outpatient access payment equal to \$24,000,000 multiplied  
19 by a fraction, the numerator of which is the hospital's  
20 Fiscal Year 2015 outpatient services and the denominator of  
21 which is the Fiscal Year 2015 outpatient services for all  
22 hospitals eligible under this paragraph for this payment.

23 (n) Psychiatric care access payment. In addition to rates  
24 paid for inpatient psychiatric services, the Illinois  
25 Department shall, by rule, establish an access payment for  
26 inpatient hospital psychiatric services that shall, in the



1 aggregate, spend approximately \$61,141,188 annually. In  
2 consultation with the hospital community, the Department may,  
3 by rule, incorporate the funds used for this access payment to  
4 increase the payment rates for inpatient psychiatric services,  
5 except that such changes shall not take effect before July 1,  
6 2019. Upon incorporation into the claims payment rates, this  
7 access payment shall be repealed. Beginning July 1, 2018, for  
8 purposes of determining for State fiscal years 2019 and 2020  
9 the hospitals eligible for the payments authorized under this  
10 subsection, the Department shall include out-of-state  
11 hospitals that are designated a Level I pediatric trauma center  
12 or a Level I trauma center by the Department of Public Health  
13 as of December 1, 2017.

14 (o) For purposes of this Section, a hospital that is  
15 enrolled to provide Medicaid services during State fiscal year  
16 2015 shall have its utilization and associated reimbursements  
17 annualized prior to the payment calculations being performed  
18 under this Section.

19 (p) Definitions. As used in this Section, unless the  
20 context requires otherwise:

21 "General acute care admissions" means, for a given  
22 hospital, the sum of inpatient hospital admissions provided to  
23 recipients of medical assistance under Title XIX of the Social  
24 Security Act for general acute care, excluding admissions for  
25 individuals eligible for Medicare under Title XVIII of the  
26 Social Security Act (Medicaid/Medicare crossover admissions),

1 as tabulated from the Department's paid claims data for general  
2 acute care admissions occurring during State fiscal year 2015  
3 that was adjudicated by the Department through October 28,  
4 2016.

5 "Occupancy ratio" is determined utilizing the IDPH  
6 Hospital Profile CY15 - Facility Utilization Data - Source 2015  
7 Annual Hospital Questionnaire. Utilizes all beds and days  
8 including observation days but excludes Long Term Care and  
9 Swing bed and their associated beds and days.

10 "Outpatient services" means, for a given hospital, the sum  
11 of the number of outpatient encounters identified as unique  
12 services provided to recipients of medical assistance under  
13 Title XIX of the Social Security Act for general acute care,  
14 psychiatric care, and rehabilitation care, excluding  
15 outpatient services for individuals eligible for Medicare  
16 under Title XVIII of the Social Security Act (Medicaid/Medicare  
17 crossover services), as tabulated from the Department's paid  
18 claims data for outpatient services occurring during State  
19 fiscal year 2015 that was adjudicated by the Department through  
20 October 28, 2016.

21 "Total days" means, for a given hospital, the sum of  
22 inpatient hospital days provided to recipients of medical  
23 assistance under Title XIX of the Social Security Act for  
24 general acute care, psychiatric care, and rehabilitation care,  
25 excluding days for individuals eligible for Medicare under  
26 Title XVIII of the Social Security Act (Medicaid/Medicare

1 crossover days), as tabulated from the Department's paid claims  
2 data for total days occurring during State fiscal year 2015  
3 that was adjudicated by the Department through October 28,  
4 2016.

5 "Total admissions" means, for a given hospital, the sum of  
6 inpatient hospital admissions provided to recipients of  
7 medical assistance under Title XIX of the Social Security Act  
8 for general acute care, psychiatric care, and rehabilitation  
9 care, excluding admissions for individuals eligible for  
10 Medicare under Title XVIII of that Act (Medicaid/Medicare  
11 crossover admissions), as tabulated from the Department's paid  
12 claims data for admissions occurring during State fiscal year  
13 2015 that was adjudicated by the Department through October 28,  
14 2016.

15 (q) Notwithstanding any of the other provisions of this  
16 Section, the Department is authorized to adopt rules that  
17 change the hospital access payments specified in this Section,  
18 but only to the extent necessary to conform to any federally  
19 approved amendment to the Title XIX State Plan. Any such rules  
20 shall be adopted by the Department as authorized by Section  
21 5-50 of the Illinois Administrative Procedure Act.  
22 Notwithstanding any other provision of law, any changes  
23 implemented as a result of this subsection (q) shall be given  
24 retroactive effect so that they shall be deemed to have taken  
25 effect as of the effective date of this amendatory Act of the  
26 100th General Assembly.

1           (r) (1) On or after July 1, 2018, and no less than annually  
2 thereafter, the Department shall calculate increased ~~increase~~  
3 capitation payments to capitated managed care organizations  
4 (MCOs) to equal the aggregate reduction of payments made in  
5 this Section to preserve access to hospital services for  
6 recipients under the Medical Assistance Program. The  
7 calculated aggregate amount of all increased capitation  
8 payments to all MCOs for a fiscal year shall at least be the  
9 amount needed to avoid reduction in payments authorized under  
10 Section 5A-15.

11           (2) On or after July 1, 2018, and no less than annually  
12 thereafter until the changes described in paragraph (3) are  
13 implemented, the Department shall increase capitation payments  
14 to MCOs by the amount calculated under paragraph (1). Payments  
15 to MCOs under this Section shall be consistent with actuarial  
16 certification and shall be published by the Department each  
17 year. Managed care organizations and hospitals ~~(including~~  
18 ~~through their representative organizations)~~, shall develop and  
19 implement methodologies and rates for payments that will  
20 preserve and improve access to hospital services for recipients  
21 in furtherance of the State's public policy to ensure equal  
22 access to covered services to recipients under the Medical  
23 Assistance Program. The Department shall make available, on a  
24 monthly basis, a report of the capitation payments that are  
25 made to each MCO, including the number of enrollees for which  
26 such payment is made, the per enrollee amount of the payment,

1 and any adjustments that have been made. Following the  
2 effective date of this amendatory Act of the 101st General  
3 Assembly, each MCO shall expend at least an amount equivalent  
4 to the increased capitation payments it receives under this  
5 Section to support the availability of hospital services and to  
6 ensure access to hospital services in furtherance of the  
7 State's public policy. Each MCO shall submit to the Department  
8 and the Department shall make available, on a monthly basis, a  
9 report of each payment to a hospital in accordance with  
10 methodologies and rates to preserve and improve access to  
11 hospital services. Payments to MCOs that would be paid  
12 consistent with actuarial certification and enrollment in the  
13 absence of the increased capitation payments under this Section  
14 shall not be reduced as a consequence of payments made under  
15 this subsection.

16 (3) Following the effective date of this amendatory Act of  
17 the 101st General Assembly, contracts between the Department  
18 and MCOs for subsequent plan years shall require MCOs to pass  
19 through the payment amounts in accordance with this Section  
20 reduced and added up to the aggregate amount calculated under  
21 paragraph (1), in conformance with 42 CFR 438.6. Each MCO shall  
22 submit to the Department and the Department shall make  
23 available, on a quarterly basis, a report of each payment to a  
24 hospital in accordance with this paragraph.

25 (4) As used in this subsection, "MCO" means an entity which  
26 contracts with the Department to provide services where payment

1 for medical services is made on a capitated basis.

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

3 (305 ILCS 5/5A-13)

4 Sec. 5A-13. Emergency rulemaking.

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

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

22 (c) The Department of Healthcare and Family Services may  
23 adopt rules necessary to initially implement the changes to  
24 Articles 5, 5A, 12, and 14 of this Code under this amendatory  
25 Act of the 100th General Assembly through the use of emergency

1 rulemaking in accordance with subsection (aa) of Section 5-45  
2 of the Illinois Administrative Procedure Act. For purposes of  
3 that Act, the General Assembly finds that the adoption of rules  
4 to implement the changes to Articles 5, 5A, 12, and 14 of this  
5 Code under this amendatory Act of the 100th General Assembly is  
6 deemed an emergency and necessary for the public interest,  
7 safety, and welfare. The 24-month limitation on the adoption of  
8 emergency rules does not apply to rules adopted to initially  
9 implement the changes to Articles 5, 5A, 12, and 14 of this  
10 Code under this amendatory Act of the 100th General Assembly.  
11 For purposes of this subsection, "initially" means any  
12 emergency rules necessary to immediately implement the changes  
13 authorized to Articles 5, 5A, 12, and 14 of this Code under  
14 this amendatory Act of the 100th General Assembly; however,  
15 emergency rulemaking authority shall not be used to make  
16 changes that could otherwise be made following the process  
17 established in the Illinois Administrative Procedure Act.

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

1 amendatory Act of the 100th General Assembly is deemed an  
2 emergency and necessary for the public interest, safety, and  
3 welfare. The 24-month limitation on the adoption of emergency  
4 rules does not apply to rules adopted to initially implement  
5 the changes to Articles 5A and 14 of this Code under this  
6 amendatory Act of the 100th General Assembly.

7 (e) The Department of Healthcare and Family Services may  
8 adopt rules necessary to initially implement the changes made  
9 by this amendatory Act of the 101st General Assembly to  
10 Sections 5A-2, 5A-12.6, 5A-14, and 14-12 of this Code through  
11 the use of emergency rulemaking in accordance with the Illinois  
12 Administrative Procedure Act. For purposes of the Illinois  
13 Administrative Procedure Act Act, the General Assembly finds  
14 that the adoption of rules to implement the changes made by  
15 this amendatory Act of the 101st General Assembly to Sections  
16 5A-2, 5A-12.6, 5A-14, and 14-12 of this Code is deemed an  
17 emergency and necessary for the public interest, safety, and  
18 welfare. The 24-month limitation on the adoption of emergency  
19 rules does not apply to rules adopted to initially implement  
20 the changes made by this amendatory Act of the 101st General  
21 Assembly to Sections 5A-2, 5A-12.6, 5A-14, and 14-12 of this  
22 Code. As used in this subsection, "initially" means any  
23 emergency rules necessary to immediately implement the changes  
24 made by this amendatory Act of the 101st General Assembly to  
25 Sections 5A-2, 5A-12.6, 5A-14, and 14-12 of this Code. However,  
26 emergency rulemaking authority shall not be used to make



1 changes that could otherwise be made following the process  
2 established in the Illinois Administrative Procedure Act.

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

4 (305 ILCS 5/5A-14)

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

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

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

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

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

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

12 (f) Section 5A-12.6 is repealed on July 1, 2022 ~~2020~~.

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

14 (305 ILCS 5/14-12)

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

18 (a) Inpatient hospital services. Effective for discharges  
19 on and after July 1, 2014, reimbursement for inpatient general  
20 acute care services shall utilize the All Patient Refined  
21 Diagnosis Related Grouping (APR-DRG) software, version 30,  
22 distributed by 3M<sup>TM</sup> Health Information System.

23 (1) The Department shall establish Medicaid weighting  
24 factors to be used in the reimbursement system established

1 under this subsection. Initial weighting factors shall be  
2 the weighting factors as published by 3M Health Information  
3 System, associated with Version 30.0 adjusted for the  
4 Illinois experience.

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

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

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

23 (5) The Department shall define those hospitals or  
24 distinct parts of hospitals that shall be exempt from the  
25 APR-DRG reimbursement system established under this  
26 Section. The Department shall publish these hospitals'

1 inpatient rates on its website no later than 10 calendar  
2 days prior to their effective date.

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

8 (7) Beginning July 1, 2014 and ending on June 30, 2020,  
9 or upon implementation of inpatient psychiatric rate  
10 increases as described in subsection (n) of Section  
11 5A-12.6, in addition to the statewide-standardized amount,  
12 the Department shall develop an adjustor to adjust the rate  
13 of reimbursement for Illinois freestanding inpatient  
14 psychiatric hospitals that are not designated as  
15 children's hospitals by the Department but are primarily  
16 treating patients under the age of 21.

17 (7.5) (Blank). ~~Beginning July 1, 2020, the~~  
18 ~~reimbursement for inpatient psychiatric services shall be~~  
19 ~~so that base claims projected reimbursement is increased by~~  
20 ~~an amount equal to the funds allocated in paragraph (2) of~~  
21 ~~subsection (b) of Section 5A-12.6, less the amount~~  
22 ~~allocated under paragraphs (8) and (9) of this subsection~~  
23 ~~and paragraphs (3) and (4) of subsection (b) multiplied by~~  
24 ~~13%. Beginning July 1, 2022, the reimbursement for~~  
25 ~~inpatient psychiatric services shall be so that base claims~~  
26 ~~projected reimbursement is increased by an amount equal to~~

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

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

19 (9) Beginning July 1, 2018, in addition to the  
20 statewide-standardized amount, the Department shall apply  
21 the same adjustor that is applied to trauma cases as of  
22 December 31, 2017 to inpatient claims to treat patients  
23 with burns, including, but not limited to, APR-DRGs 841,  
24 842, 843, and 844.

25 (10) Beginning July 1, 2018, the  
26 statewide-standardized amount for inpatient general acute

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

1 ~~subsection (b) of Section 5A-12.6, less the amount~~  
2 ~~allocated under paragraphs (8) and (9) of this subsection~~  
3 ~~and paragraphs (3) and (4) of subsection (b) multiplied by~~  
4 ~~40%.~~

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

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

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

24 ~~Beginning July 1, 2023, the reimbursement for~~  
25 ~~inpatient rehabilitation services shall be uniformly~~  
26 ~~increased so that the \$96 per day add on as adjusted by the~~

1 ~~July 1, 2022 increase, is increased by an amount equal to~~  
2 ~~the funds allocated in paragraph (4) of subsection (b) of~~  
3 ~~Section 5A-12.6, less the amount allocated under~~  
4 ~~paragraphs (8) and (9) of this subsection and paragraphs~~  
5 ~~(3) and (4) of subsection (b) multiplied by 0.9%.~~

6 (12) Beginning July 1, 2020, the reimbursement for  
7 inpatient general acute care services to non-publicly  
8 owned safety net hospitals, as defined in Section 5-5e.1 of  
9 this Code for Rate Year 2017, shall be increased by a  
10 uniform dollar amount so that base claims projected  
11 reimbursement is increased by an amount equal to  
12 \$400,000,000 of the funds allocated in paragraph (2) of  
13 subsection (b) of Section 5A-12.6.

14 (13) Beginning July 1, 2020, the reimbursement for  
15 inpatient general acute care services to non-publicly  
16 owned critical access hospitals shall be increased by a  
17 uniform dollar amount so that base claims projected  
18 reimbursement is increased by an amount equal to  
19 \$100,000,000 of the funds allocated in paragraph (2) of  
20 subsection (b) of Section 5A-12.6.

21 (14) Beginning July 1, 2020, the reimbursement for  
22 inpatient general acute care services to hospital  
23 providers in high-need communities shall be increased by a  
24 uniform dollar amount so that base claims projected  
25 reimbursement is increased by an amount equal to  
26 \$500,000,000 of the funds allocated in paragraph (2) of

1 subsection (b) of Section 5A-12.6. A hospital shall qualify  
2 as a hospital in a high-need community if it is located in  
3 a census tract with median household income below the  
4 statewide median household income, is located in a census  
5 tract with life expectancy below the statewide average, and  
6 has a Medicaid inpatient utilization rate at or above the  
7 statewide median.

8 (15) Beginning July 1, 2020, the reimbursement for  
9 inpatient psychiatric services to non-publicly owned  
10 general acute care hospitals shall be increased by a  
11 uniform dollar amount so that base claims projected  
12 reimbursement is increased by an amount equal to  
13 \$61,000,000 of the funds allocated in paragraph (2) of  
14 subsection (b) of Section 5A-12.6.

15 (b) Outpatient hospital services. Effective for dates of  
16 service on and after July 1, 2014, reimbursement for outpatient  
17 services shall utilize the Enhanced Ambulatory Procedure  
18 Grouping (EAPG) software, version 3.7 distributed by 3M<sup>TM</sup>  
19 Health Information System.

20 (1) The Department shall establish Medicaid weighting  
21 factors to be used in the reimbursement system established  
22 under this subsection. The initial weighting factors shall  
23 be the weighting factors as published by 3M Health  
24 Information System, associated with Version 3.7.

25 (2) The Department shall establish service specific  
26 statewide-standardized amounts to be used in the



1 reimbursement system.

2 (A) The initial statewide standardized amounts,  
3 with the labor portion adjusted by the Calendar Year  
4 2013 Medicare Outpatient Prospective Payment System  
5 wage index with reclassifications, shall be published  
6 by the Department on its website no later than 10  
7 calendar days prior to their effective date.

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

20 (3) In addition to the statewide-standardized amounts,  
21 the Department shall develop adjusters to adjust the rate  
22 of reimbursement for critical Medicaid hospital outpatient  
23 providers or services, including outpatient high volume or  
24 safety-net hospitals. Beginning July 1, 2018, the  
25 outpatient high volume adjustor shall be increased to  
26 increase annual expenditures associated with this adjustor

1 by \$79,200,000, based on the State Fiscal Year 2015 base  
2 year data and this adjustor shall apply to public  
3 hospitals, except for large public hospitals, as defined  
4 under 89 Ill. Adm. Code 148.25(a).

5 (4) Beginning July 1, 2018, in addition to the  
6 statewide standardized amounts, the Department shall make  
7 an add-on payment for outpatient expensive devices and  
8 drugs. This add-on payment shall at least apply to claim  
9 lines that: (i) are assigned with one of the following  
10 EAPGs: 490, 1001 to 1020, and coded with one of the  
11 following revenue codes: 0274 to 0276, 0278; or (ii) are  
12 assigned with one of the following EAPGs: 430 to 441, 443,  
13 444, 460 to 465, 495, 496, 1090. The add-on payment shall  
14 be calculated as follows: the claim line's covered charges  
15 multiplied by the hospital's total acute cost to charge  
16 ratio, less the claim line's EAPG payment plus \$1,000,  
17 multiplied by 0.8.

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

1 the statewide-standardized amounts for outpatient services  
2 shall be increased by a uniform percentage so that base  
3 claims projected reimbursement is increased by an amount  
4 equal to no less than the funds allocated in paragraph (2)  
5 of subsection (b) of Section 5A-12.6, less the amount  
6 allocated under paragraphs (8) and (9) of subsection (a)  
7 and paragraphs (3) and (4) of this subsection multiplied by  
8 46%. ~~Beginning July 1, 2022, the statewide standardized~~  
9 ~~amounts for outpatient services shall be increased by a~~  
10 ~~uniform percentage so that base claims projected~~  
11 ~~reimbursement is increased by an amount equal to the funds~~  
12 ~~allocated in paragraph (3) of subsection (b) of Section~~  
13 ~~5A-12.6, less the amount allocated under paragraphs (8) and~~  
14 ~~(9) of subsection (a) and paragraphs (3) and (4) of this~~  
15 ~~subsection multiplied by 46%. Beginning July 1, 2023, the~~  
16 ~~statewide standardized amounts for outpatient services~~  
17 ~~shall be increased by a uniform percentage so that base~~  
18 ~~claims projected reimbursement is increased by an amount~~  
19 ~~equal to no less than the funds allocated in paragraph (4)~~  
20 ~~of subsection (b) of Section 5A-12.6, less the amount~~  
21 ~~allocated under paragraphs (8) and (9) of subsection (a)~~  
22 ~~and paragraphs (3) and (4) of this subsection multiplied by~~  
23 ~~46%.~~

24 (6) Effective for dates of service on or after July 1,  
25 2018, the Department shall establish adjustments to the  
26 statewide-standardized amounts for each Critical Access

1 Hospital, as designated by the Department of Public Health  
2 in accordance with 42 CFR 485, Subpart F, such that each  
3 Critical Access Hospital's standardized amount for  
4 outpatient services shall be increased by the applicable  
5 uniform dollar amount ~~percentage~~ determined pursuant to  
6 paragraph (5) of this subsection. It is the intent of the  
7 General Assembly that the adjustments required under this  
8 paragraph (6) by Public Act 100-1181 ~~this amendatory Act of~~  
9 ~~the 100th General Assembly~~ shall be applied retroactively  
10 to claims for dates of service provided on or after July 1,  
11 2018.

12 (7) Effective for dates of service on or after March 8,  
13 2019 (the effective date of Public Act 100-1181) ~~this~~  
14 ~~amendatory Act of the 100th General Assembly~~, the  
15 Department shall recalculate and implement an updated  
16 statewide-standardized amount for outpatient services  
17 provided by hospitals that are not Critical Access  
18 Hospitals to reflect the applicable uniform dollar amount  
19 ~~percentage~~ determined pursuant to paragraph (5).

20 (1) Any recalculation to the  
21 statewide-standardized amounts for outpatient services  
22 provided by hospitals that are not Critical Access  
23 Hospitals shall be the amount necessary to achieve the  
24 increase in the statewide-standardized amounts for  
25 outpatient services increased by a uniform dollar  
26 amount ~~percentage~~, so that base claims projected

1 reimbursement is increased by an amount equal to no  
2 less than the funds allocated in paragraph (1) of  
3 subsection (b) of Section 5A-12.6, less the amount  
4 allocated under paragraphs (8), (9), and (12) through  
5 (15) ~~and (9)~~ of subsection (a) and paragraphs (3) and  
6 (4) of this subsection, for all hospitals that are not  
7 Critical Access Hospitals, multiplied by 46%.

8 (2) It is the intent of the General Assembly that  
9 the recalculations required under this paragraph (7)  
10 by Public Act 100-1181 ~~this amendatory Act of the 100th~~  
11 ~~General Assembly~~ shall be applied prospectively to  
12 claims for dates of service provided on or after March  
13 8, 2019 (the effective date of Public Act 100-1181)  
14 ~~this amendatory Act of the 100th General Assembly~~ and  
15 that no recoupment or repayment by the Department or an  
16 MCO of payments attributable to recalculation under  
17 this paragraph (7), issued to the hospital for dates of  
18 service on or after July 1, 2018 and before March 8,  
19 2019 (the effective date of Public Act 100-1181) ~~this~~  
20 ~~amendatory Act of the 100th General Assembly~~, shall be  
21 permitted.

22 (8) The Department shall ensure that all necessary  
23 adjustments to the managed care organization capitation  
24 base rates necessitated by the adjustments under  
25 subparagraph (6) or (7) of this subsection are completed  
26 and applied retroactively in accordance with Section

1           5-30.8 of this Code within 90 days of March 8, 2019 (the  
2           effective date of Public Act 100-1181) ~~this amendatory Act~~  
3           ~~of the 100th General Assembly.~~

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

14          (d) Transition period. There shall be a transition period  
15          to the reimbursement systems authorized under this Section that  
16          shall begin on the effective date of these systems and continue  
17          until June 30, 2018, unless extended by rule by the Department.  
18          To help provide an orderly and predictable transition to the  
19          new reimbursement systems and to preserve and enhance access to  
20          the hospital services during this transition, the Department  
21          shall allocate a transitional hospital access pool of at least  
22          \$290,000,000 annually so that transitional hospital access  
23          payments are made to hospitals.

24                 (1) After the transition period, the Department may  
25                 begin incorporating the transitional hospital access pool  
26                 into the base rate structure; however, the transitional

1 hospital access payments in effect on June 30, 2018 shall  
2 continue to be paid, if continued under Section 5A-16.

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

12 (d-5) Hospital transformation program. The Department, in  
13 conjunction with the Hospital Transformation Review Committee  
14 created under subsection (d-5), shall develop a hospital  
15 transformation program to provide financial assistance to  
16 hospitals in areas of greatest health need and areas most  
17 adversely affected by health disparities that require such  
18 assistance to transform or expand ~~in transforming~~ their  
19 services and care models to better meet ~~align with~~ the needs of  
20 the communities they serve. The payments authorized in this  
21 Section shall be subject to approval by the federal government.

22 (1) Phase 1. In State fiscal years 2019 through 2020,  
23 the Department shall allocate funds from the transitional  
24 access hospital pool to create a hospital transformation  
25 pool of at least \$262,906,870 annually and make hospital  
26 transformation payments to hospitals. Subject to Section

1           5A-16, in State fiscal years 2019 and 2020, an Illinois  
2           hospital that received either a transitional hospital  
3           access payment under subsection (d) or a supplemental  
4           payment under subsection (f) of this Section in State  
5           fiscal year 2018, shall receive a hospital transformation  
6           payment as follows:

7                   (A) If the hospital's Rate Year 2017 Medicaid  
8                   inpatient utilization rate is equal to or greater than  
9                   45%, the hospital transformation payment shall be  
10                  equal to 100% of the sum of its transitional hospital  
11                  access payment authorized under subsection (d) and any  
12                  supplemental payment authorized under subsection (f).

13                   (B) If the hospital's Rate Year 2017 Medicaid  
14                   inpatient utilization rate is equal to or greater than  
15                   25% but less than 45%, the hospital transformation  
16                  payment shall be equal to 75% of the sum of its  
17                  transitional hospital access payment authorized under  
18                  subsection (d) and any supplemental payment authorized  
19                  under subsection (f).

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

26                  (2) Phase 2. In State Fiscal Year 2021, the Department



1 shall allocate the funds from the transitional access  
2 hospital pool in the same manner as for Phase 1 as  
3 described in paragraph (1). In addition, during State  
4 Fiscal Year 2021 the Department shall prepare and make  
5 available to hospitals data on health disparities for their  
6 use in planning improvements by which they can address  
7 negative impacts of health disparities in communities they  
8 serve. If necessary an amount not to exceed \$20,000,000  
9 shall be available from the Hospital Provider Fund for the  
10 Department as a health disparities pay-for-collection pool  
11 to pay health care providers for collection of  
12 patient-level data, such as on race and ethnicity,  
13 sufficient to serve as the baseline year for measuring  
14 improvement or lack of improvement in health disparities  
15 and for adjustment of payments based on health disparities  
16 in future years. In addition, during State Fiscal Year  
17 2021, the Department, in conjunction with the Hospital  
18 Transformation Review Committee, shall complete a  
19 stakeholder process to determine the priorities of the  
20 hospital transformation program, including at a minimum  
21 the following:

22 (A) The Department, in conjunction with the  
23 Hospital Transformation Review Committee, shall  
24 provide an opportunity for public input and formal  
25 mechanism for stakeholder participation in identifying  
26 priority delivery system reform and improvement

1 purposes for the transformation program based on  
2 community health needs.

3 (B) The Department, in conjunction with the  
4 Hospital Transformation Review Committee, shall  
5 conduct no fewer than 6 hearings for this purpose. No  
6 fewer than 2 of these hearings shall be held in the  
7 City of Chicago, and at least one additional hearing  
8 shall be held in another location in Cook County.

9 (C) The Department shall publish a report with the  
10 results of this process on its website.

11 (3) Phase 3. During State fiscal years 2021 and 2022  
12 and thereafter, the Department shall allocate funds from  
13 the transitional access hospital pool to create a hospital  
14 transformation pool annually and make hospital  
15 transformation payments from the hospital transformation  
16 pool to hospitals participating in the transformation  
17 program. Hospitals in areas of greatest health need and  
18 areas most adversely affected by health disparities that  
19 require assistance to transform or expand their services to  
20 better meet the needs of communities they serve, as defined  
21 in rules adopted in accordance with subparagraph (B) of  
22 paragraph 4, Any hospital may seek transformation funding  
23 in Phase 3, however, that priority shall be given to  
24 Disproportionate Share Hospitals and Critical Access  
25 Hospitals 2. Any hospital that seeks transformation  
26 funding in Phase 3 2 to update or repurpose the hospital's

1 ~~physical structure to transition to a new delivery model,~~  
2 must submit to the Department in writing a transformation  
3 plan, based on the Department's guidelines, that describes  
4 the changes or service expansions it seeks to make and  
5 selects process and outcome measures, from a set developed  
6 by the Department, the hospital will meet through the  
7 course of the transformation project; a timeline for the  
8 transformation plan; as well as financial information  
9 sufficient to allow the Department to determine whether the  
10 changes or service expansions could occur but for  
11 transformation program funding. ~~desired delivery model~~  
12 ~~with projections of patient volumes by service lines and~~  
13 ~~projected revenues, expenses, and net income that~~  
14 ~~correspond to the new delivery model.~~ In Phase 3 2, subject  
15 to the approval of rules, the Department may use the  
16 hospital transformation pool to increase base rates,  
17 develop new adjustors, or adjust current adjustors, ~~or~~  
18 ~~develop new access payments~~ in order to support and  
19 incentivize hospitals pursuing ~~to~~ ~~pursue~~ such  
20 transformation. In developing such methodologies, the  
21 Department shall ensure that the entire hospital  
22 transformation pool continues to be expended to ensure  
23 access to hospital services. If necessary an amount not to  
24 exceed \$20,000,000 per year shall be available from the  
25 Hospital Provider Fund for the Department as a disparities  
26 pay-for-collection pool to pay health care providers for

1 collection of patient-level data, such as on race and  
2 ethnicity, sufficient to serve as the baseline year for  
3 measuring improvement or lack of improvement in health  
4 disparities and for adjustment of payments based on health  
5 disparities in future years. The Department annually shall  
6 allocate to the hospital transformation pool funds from the  
7 transitional access hospital pool; any unused amount from  
8 the \$20,000,000 health disparities pay-for-collection  
9 pool; and \$120,000,000 from the Hospital Provider Fund. ~~or~~  
10 ~~to support organizations that had received hospital~~  
11 ~~transformation payments under this Section.~~

12 (A) Any hospital participating in the hospital  
13 transformation program shall provide an opportunity  
14 for public input by local community groups, hospital  
15 workers, and healthcare professionals and assist in  
16 facilitating discussions about any transformations or  
17 changes to the hospital.

18 (A-5) Any hospital that seeks to commit  
19 transformation funding to capital spending shall  
20 submit to the Department in writing a transformation  
21 plan, based on the Department's guidelines, that  
22 describes the proposed changes to the hospital's  
23 physical facilities with projections of patient  
24 volumes by service lines and projected revenues,  
25 expenses, and net income.

26 (B) As provided in paragraph (9) of Section 3 of

1 the Illinois Health Facilities Planning Act, any  
2 hospital seeking to expand services through  
3 ~~participating in~~ the transformation program may be  
4 excluded from the requirements of the Illinois Health  
5 Facilities Planning Act for those projects related to  
6 the hospital's transformation. To be eligible, the  
7 hospital must submit to the Health Facilities and  
8 Services Review Board certification from the  
9 Department, approved by the Hospital Transformation  
10 Review Committee, that the project is a part of the  
11 hospital's transformation.

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

22 (4) (A) By August 1, 2020 the Department, in conjunction  
23 with the Hospital Transformation Review Committee, shall  
24 develop and file administrative rules with the Secretary of  
25 State setting forth processes for data collection and  
26 payment from the health disparities pay-for-collection

1 pool.

2 (B) By March 1, 2021 ~~(3) By April 1, 2019 March 12,~~  
3 ~~2018 (Public Act 100-581)~~ the Department, in conjunction  
4 with the Hospital Transformation Review Committee, shall  
5 develop and file as an administrative rule with the  
6 Secretary of State the goals, objectives, policies,  
7 standards, payment models, process and outcome measures,  
8 or criteria to be applied in Phase 3 ~~2~~ of the program to  
9 allocate the hospital transformation funds. The goals,  
10 objectives, and policies to be considered may include, but  
11 are not limited to, reducing health disparities; achieving  
12 unmet needs of a community that a hospital serves such as  
13 behavioral health services, outpatient services, or drug  
14 rehabilitation services; attaining certain quality or  
15 patient safety benchmarks for health care services; or  
16 improving the coordination, effectiveness, and efficiency  
17 of care delivery. The rulemaking shall direct managed care  
18 organizations (MCOs) to make payments under this  
19 subsection (d-5) in a manner conforming with 42 CFR 438.6  
20 regarding payments directed to be made by MCOs as part of a  
21 delivery system reform and improvement initiatives.  
22 Notwithstanding any other provision of law, any rule  
23 adopted in accordance with this subsection (d-5) may be  
24 submitted to the Joint Committee on Administrative Rules  
25 for approval only if the rule has first been approved by 9  
26 of the 14 members of the Hospital Transformation Review

1 Committee.

2 (5) ~~(4)~~ Hospital Transformation Review Committee.

3 There is created the Hospital Transformation Review  
4 Committee. The Committee shall consist of 14 members. No  
5 later than 30 days after March 12, 2018 (the effective date  
6 of Public Act 100-581), the 4 legislative leaders shall  
7 each appoint 3 members; the Governor shall appoint the  
8 Director of Healthcare and Family Services, or his or her  
9 designee, as a member; and the Director of Healthcare and  
10 Family Services shall appoint one member. Any vacancy shall  
11 be filled by the applicable appointing authority within 15  
12 calendar days. The members of the Committee shall select a  
13 Chair and a Vice-Chair from among its members, provided  
14 that the Chair and Vice-Chair cannot be appointed by the  
15 same appointing authority and must be from different  
16 political parties. The Chair shall have the authority to  
17 establish a meeting schedule and convene meetings of the  
18 Committee, and the Vice-Chair shall have the authority to  
19 convene meetings in the absence of the Chair. The Committee  
20 may establish its own rules with respect to meeting  
21 schedule, notice of meetings, and the disclosure of  
22 documents; however, the Committee shall not have the power  
23 to subpoena individuals or documents and any rules must be  
24 approved by 9 of the 14 members. The Committee shall  
25 perform the functions described in this Section and advise  
26 and consult with the Director in the administration of this

1 Section. In addition to reviewing and approving the  
2 policies, procedures, and rules for the hospital  
3 transformation program, the Committee shall consider and  
4 make recommendations related to qualifying criteria and  
5 payment methodologies related to safety-net hospitals and  
6 children's hospitals. Members of the Committee appointed  
7 by the legislative leaders shall be subject to the  
8 jurisdiction of the Legislative Ethics Commission, not the  
9 Executive Ethics Commission, and all requests under the  
10 Freedom of Information Act shall be directed to the  
11 applicable Freedom of Information officer for the General  
12 Assembly. The Department shall provide operational support  
13 to the Committee as necessary. ~~The Committee is dissolved~~  
14 ~~on April 1, 2019.~~

15 (6) Definitions. As used in this Section:

16 "Managed care organization" or "MCO" means an entity  
17 which contracts with the Department to provide services  
18 where payment for medical services is made on a capitated  
19 basis.

20 "Health disparities" mean preventable differences in  
21 the burden of disease, injury, violence, or opportunities  
22 to achieve optimal health that are experienced by socially  
23 disadvantaged populations.

24  
25 (e) Beginning 36 months after initial implementation, the  
26 Department shall update the reimbursement components in



1 subsections (a) and (b), including standardized amounts and  
2 weighting factors, and at least triennially and no more  
3 frequently than annually thereafter. The Department shall  
4 publish these updates on its website no later than 30 calendar  
5 days prior to their effective date.

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

12 (g) Notwithstanding subsections (a) through (f) of this  
13 Section and notwithstanding the changes authorized under  
14 Section 5-5b.1, any updates to the system shall not result in  
15 any diminishment of the overall effective rates of  
16 reimbursement as of the implementation date of the new system  
17 (July 1, 2014). These updates shall not preclude variations in  
18 any individual component of the system or hospital rate  
19 variations. Nothing in this Section shall prohibit the  
20 Department from increasing the rates of reimbursement or  
21 developing payments to ensure access to hospital services.  
22 Nothing in this Section shall be construed to guarantee a  
23 minimum amount of spending in the aggregate or per hospital as  
24 spending may be impacted by factors, including, but not limited  
25 to, the number of individuals in the medical assistance program  
26 and the severity of illness of the individuals.

1           (h) (1) The Department shall have the authority to modify by  
2 rulemaking any changes to the rates or methodologies in this  
3 Section as required by the federal government to obtain federal  
4 financial participation for expenditures made under this  
5 Section.

6           (2) The Department shall have the authority to adjust by  
7 rulemaking payment methodologies in this Section if such  
8 adjustments are required by the federal government to conform  
9 with 42 CFR 438.6 regarding payments directed to be made by  
10 MCOs.

11           (i) Except for subsections (g) and (h) of this Section, the  
12 Department shall, pursuant to subsection (c) of Section 5-40 of  
13 the Illinois Administrative Procedure Act, provide for  
14 presentation at the June 2014 hearing of the Joint Committee on  
15 Administrative Rules (JCAR) additional written notice to JCAR  
16 of the following rules in order to commence the second notice  
17 period for the following rules: rules published in the Illinois  
18 Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559  
19 (Medical Payment), 4628 (Specialized Health Care Delivery  
20 Systems), 4640 (Hospital Services), 4932 (Diagnostic Related  
21 Grouping (DRG) Prospective Payment System (PPS)), and 4977  
22 (Hospital Reimbursement Changes), and published in the  
23 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499  
24 (Specialized Health Care Delivery Systems) and 6505 (Hospital  
25 Services).

26           (j) Out-of-state hospitals. Beginning July 1, 2018, for

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

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

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

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

1 INDEX

2 Statutes amended in order of appearance

3 5 ILCS 100/5-45.1 new

4 210 ILCS 50/32.5

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

6 305 ILCS 5/5A-12.6

7 305 ILCS 5/5A-13

8 305 ILCS 5/5A-14

9 305 ILCS 5/14-12