HB5280

LRB10119340KTG68811b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB5280

by Rep. Emanuel Chris Welch

SYNOPSIS AS INTRODUCED:

210 ILCS 50/32.5
305 ILCS 5/5A-2 from Ch. 23, par. 5A-2
305 ILCS 5/5A-12.6
305 ILCS 5/5A-14
305 ILCS 5/14-12

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); the allocation of funds from the transitional access hospital pool; and other matters. 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 19340 KTG 68811 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 1. Legislative intent.

(1) Illinois must dedicate itself to eliminating inequities in its health care system. According to a well-known 2019 study from the New York University School of Medicine, residents of the Streeterville neighborhood of Chicago live 30 years longer than residents of the Englewood neighborhood on average, the worst such disparity identified in the nation.

(2) In order to address disparities in health care access and outcomes, every community must have access to high quality and comprehensive health care services. This means investing in the health care delivery system in an equitable manner, emphasizing hospitals in areas of greatest health need and most adversely affected by health disparities.

(3) Safety net hospitals, which are most often located in low-income communities of color, need greater capacity, and expanded services. Instead, there is currently a crisis of hospital closures and service scale-backs throughout the most vulnerable communities in Illinois. In contrast, large academic medical centers and hospital systems have less need for public operational support. According to financial disclosures, many of these hospitals or systems hold billions

of dollars in financial investment accounts that could otherwise be used to improve care access and quality throughout the State.

(4) The Illinois hospital assessment, a roughly $3,500,000,000 program within the Illinois Medicaid program, should be used to ensure the stability, equity, and quality of our health care delivery system. This means directing additional Medicaid funding to hospitals in urgent need of public support. Currently, the assessment awards too much supplemental funding to wealthy hospitals and hospital systems and not enough to hospitals dependent on the Medicaid program.

(5) This Act of the 101st General Assembly amends the hospital provider assessment and associated payments to reorient them toward the support of hospitals in areas of greatest health need and most adversely affected by health disparities.

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

(210 ILCS 50/32.5)

Sec. 32.5. Freestanding Emergency Center.

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

January 1, 2015, and:

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

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

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

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

(B) equipment standards; and

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

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

(5) provides comprehensive emergency treatment services, as defined in the rules adopted by the Department

pursuant to the Hospital Licensing Act, 24 hours per day, on an outpatient basis;

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

(7) (blank);

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

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

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

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

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

(13) complies with any other rules adopted by the

Department under this Act that relate to FECs;

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

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

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

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

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

(a-10) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility if the facility has, by January 1, 2014, filed a letter of intent to establish an FEC and if the facility

complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

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

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

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

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

~~(3) the facility complies with the requirements set forth in paragraphs (1) through (17), provided however that the FEC may be located in a municipality with a population~~

~~greater than 50,000 inhabitants and shall not be subject to the requirements of the Illinois Health Facilities Planning Act that are applicable to the conversion to an FEC if the Department of Healthcare and Family Service has certified the conversion to an FEC was approved by the Hospital Transformation Review Committee as a project subject to the hospital's transformation under subsection (d-5) of Section 14-12 of the Illinois Public Aid Code; and~~

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

(b) The Department shall:

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

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

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

initiated after an Emergency Suspension Order has been issued; and

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

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

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

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

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

Sec. 5A-2. Assessment.

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

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

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

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

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

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

~~Subject to Sections 5A-3 and 5A-10, for State fiscal years 2021 through 2024, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $197.19 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however, that the amount of $197.19 used to calculate the assessment under this paragraph shall, by rule, be adjusted by a uniform percentage to generate the same total annual assessment that was generated in State fiscal year 2020 from all hospitals subject to the annual assessment under this paragraph plus $6,250,000. For State fiscal years 2021 and 2022, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2017 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2019, without regard to any subsequent adjustments or changes to such data. For State fiscal years 2023 and 2024, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available~~

~~from each hospital's 2019 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2021, without regard to any subsequent adjustments or changes to such data.~~

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, or as provided in Section 5A-16, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for

that period from all hospitals subject to the annual assessment under this paragraph.

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

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, or as provided in Section 5A-16, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient

services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue; however, for State fiscal year 2021, the amount of .01358 shall be increased by a uniform percentage to generate an additional $6,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020; however, for State fiscal year 2021, the assessment amount shall be increased by the proportion that it represents of the total annual

assessment that is generated from all hospitals in order to generate $6,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

~~Subject to Sections 5A-3 and 5A-10, for State fiscal years 2021 through 2024, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue, provided however, that the amount of .01358 used to calculate the assessment under this paragraph shall, by rule, be adjusted by a uniform percentage to generate the same total annual assessment that was generated in State fiscal year 2020 from all hospitals subject to the annual assessment under this paragraph plus $6,250,000. For State fiscal years 2021 and 2022, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2017 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2019, without regard to any subsequent adjustments or changes to such data. For State fiscal years 2023 and 2024, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2019 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2021, without regard to any subsequent adjustments or changes to such data.~~

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

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

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

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under

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

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

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

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

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

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

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

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

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5,

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

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(c) (Blank).

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

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

(i) The total annual assessment on inpatient services that was generated in State fiscal year 2020 from all

hospitals subject to the annual assessment under this paragraph plus $6,250,000.

(ii) The total annual assessment on inpatient services that was generated in State fiscal year 2020 from all hospitals subject to the annual assessment under this paragraph plus $6,250,000.

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

For State Fiscal Years 2021 and 2022, a hospital's non-Medicaid gross revenue shall be determined using the most recent data available from each hospital's 2017 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2019, without regard to any subsequent adjustments or changes to such data. For State Fiscal Years 2023 and 2024, a hospital's non-Medicaid gross revenue shall be determined using the most recent data available from each hospital's 2019 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2021, without regard to any subsequent adjustments or changes to such data. If a hospital's Medicare cost report is not contained in the

Healthcare Cost Report Information System or the hospital's Medicare cost report contains insufficient information to determine gross non-Medicaid inpatient or outpatient revenue, then the Department may obtain the hospital provider's gross non-Medicaid revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. The Department may also set any additional reporting requirements for Medicare cost reports as deemed necessary to determine non-Medicaid gross revenue inpatient and outpatient revenue for future fiscal years.

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

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

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

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

(305 ILCS 5/5A-12.6)

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

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2018 the Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in

this Section. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act. In determining the hospital access payments authorized under subsections (f) through (n) of this Section, unless otherwise specified, only Illinois hospitals shall be eligible for a payment and total Medicaid utilization statistics shall be used to determine the payment amount. In determining the hospital access payments authorized under subsection (d) and subsections (f) through (l) of this Section, if a hospital ceases to receive payments from the pool, the payments for all hospitals continuing to receive payments from such pool shall be uniformly adjusted to fully expend the aggregate amount of the pool, with such adjustment being effective on the first day of the second month following the date the hospital ceases to receive payments from such pool.

(b) Phase in of funds to claims-based payments and updates. To ensure access to hospital services, the Department may only use funds financed by the assessment authorized under Section 5A-2 to increase claims-based payment rates, including applicable policy add-on payments or adjusters, in accordance with this subsection. Starting in State Fiscal Year 2021, to ~~To~~ increase the claims-based payment rates up to the amounts

specified in this subsection, the Department shall, by rule, reduce to zero any of the hospital access payments authorized in subsections (d) through (l) that it finds do not serve the purposes of ensuring equitable access to hospital services for recipients under the Medical Assistance Program by supporting hospitals in areas of greatest health need and areas most adversely affected by health disparities. Following this, the remaining hospital access payments authorized in ~~the hospital access payments authorized in~~ subsection (d) and subsections (g) through (l) of this Section shall be uniformly reduced.

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

(2) For State fiscal years 2021 and 2022, up to $1,696,000,000 ~~$1,164,000,000~~ of the total spending financed from the assessment authorized under Section 5A-2 that is intended to pay for hospital services and the hospital supplemental access payments authorized under subsections (d) and (f) of Section 14-12 for payment in State Fiscal Year 2018 may be used to increase claims-based hospital payment rates as specified under Section 14-12.

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

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

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

authorized under this Section. Any updates of the hospital access payment methodologies shall not result in any diminishment of the aggregate amount of hospital access payment expenditures, except for reductions attributable to the use of such funds to increase claims-based hospital payment rates as authorized by this Section. Nothing in this Section shall be construed as precluding variations in the amount of any individual hospital's access payments. The Department shall publish the proposed rules to update the hospital access payments at least 90 days before their proposed effective date. The proposed rules shall not be adopted using emergency rulemaking authority. The Department shall notify each hospital, in writing, of the impact of these updates on the hospital at least 30 calendar days prior to their effective date.

For purposes of this subsection, "health disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

(c) The hospital access payments authorized under subsections (d) through (n) of this Section shall be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which

time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act. The Department may, when practicable, accelerate the schedule upon which payments authorized under this Section are made.

(d) Rate increase-based adjustment.

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

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

applicable service credit factor for the hospital, divided by the total of the FY2019 claims-based payments including all FY2019 policy adjusters for each category of service adjusted by each hospital's applicable service credit factor for all qualified hospitals. For each category of service, a hospital shall receive a supplemental payment equal to its pool allocation percentage multiplied by the total pool amount.

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

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

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

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

(C) Tier 3: A hospital with a MIUR equal to or greater than 20% but less than 33% shall have a service credit factor of 50%.

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

(e) Graduate medical education.

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

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

(3) An annualized Medicaid indirect medical education (IME) payment is calculated for each hospital using its IME payments (Worksheet E Part A, Line 29, Col 1) multiplied by the percentage that its Medicaid days (Worksheet S3 Part I,

Column 7, Lines 14 and 16-18) comprise of its Medicare days (Worksheet S3 Part I, Column 6, Lines 14 and 16-18).

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

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

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

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

Year 2015 outpatient services and the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment.

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

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

deviation; or (iii) a non-publicly owned safety net hospital as defined in Section 5-5e.1 of this Code for Rate Year 2017, with total outpatient services, equal to or greater than the regional mean plus one standard deviation for all hospitals in the region.

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

(5) Each tier 3 hospital that is not publicly owned shall be paid an outpatient high volume access payment equal to $58,000,000 multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 outpatient services and the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment. A tier 3 outpatient high volume hospital means a non-publicly owned

hospital, excluding a safety-net hospital as defined in Section 5-5e.1 of this Code for Rate Year 2017, with total outpatient services equal to or greater than the regional mean plus 2 standard deviations for all hospitals in the region.

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

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

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

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

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

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

(A) Each tier 1 hospital shall be paid a Medicaid dependent hospital access payment equal to $23,000,000 multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the

denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment. A tier 1 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean but less than the statewide mean plus 0.5 standard deviation.

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

(C) Each tier 3 hospital shall be paid a Medicaid dependent hospital access payment equal to $15,000,000 multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment. A tier 3 Medicaid dependent hospital

means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus one standard deviation but less than the statewide mean plus 1.5 standard deviations.

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

(E) Each tier 5 hospital shall be paid a Medicaid dependent hospital access payment equal to $75,000,000 multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment. A tier 5 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or

greater than the statewide mean plus 2 standard deviations.

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

(i) Perinatal care access payment.

(1) Each Illinois non-publicly owned hospital designated a Level II or II+ perinatal center by the Department of Public Health as of December 1, 2017 shall be <u>assigned a pool allocation percentage equal to a fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions multiplied by the hospital's Medicaid utilization factor and the denominator of which is the sum</u>

of Fiscal Year 2015 admissions multiplied by Medicaid utilization factor for all hospitals authorized for payment under this paragraph. Each qualifying hospital shall be paid an access payment equal to $200,000,000 multiplied by its pool allocation percentage. ~~a fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.~~

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

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

(j) Trauma care access payment.

(1) Each Illinois non-publicly owned hospital designated a Level I trauma center by the Department of Public Health as of December 1, 2017 shall be paid an access payment equal to $160,000,000 multiplied by a

fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

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

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

(k) Perinatal and trauma center access payment.

(1) Each Illinois non-publicly owned hospital

designated a Level III perinatal center and a Level I or II trauma center by the Department of Public Health as of December 1, 2017, and that has a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than 20% and a calendar year 2015 occupancy ratio equal to or greater than 50%, shall be paid an access payment equal to $160,000,000 multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

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

(l) Long-term acute care access payment. Each Illinois non-publicly owned long-term acute care hospital that has a Rate Year 2017 Medicaid inpatient utilization rate equal to or

greater than 25% and a calendar year 2015 occupancy ratio equal to or greater than 60% shall be paid an access payment equal to $19,000,000 multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 general acute care admissions and the denominator of which is the Fiscal Year 2015 general acute care admissions for all hospitals eligible under this subsection for this payment.

(m) Small public hospital access payment.

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

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

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

(n) Psychiatric care access payment. In addition to rates paid for inpatient psychiatric services, the Illinois

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

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

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

"General acute care admissions" means, for a given hospital, the sum of inpatient hospital admissions provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, excluding admissions for

individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's paid claims data for general acute care admissions occurring during State fiscal year 2015 that was adjudicated by the Department through October 28, 2016.

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

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

"Total days" means, for a given hospital, the sum of inpatient hospital days provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care,

excluding days for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for total days occurring during State fiscal year 2015 that was adjudicated by the Department through October 28, 2016.

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

(q) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules that change the hospital access payments specified in this Section, but only to the extent necessary to conform to any federally approved amendment to the Title XIX State Plan. Any such rules shall be adopted by the Department as authorized by Section 5-50 of the Illinois Administrative Procedure Act. Notwithstanding any other provision of law, any changes implemented as a result of this subsection (q) shall be given retroactive effect so that they shall be deemed to have taken

effect as of the effective date of this amendatory Act of the 100th General Assembly.

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

(2) On or after July 1, 2018, and no less than annually thereafter until the changes described in paragraph (3) are implemented, the Department shall increase capitation payments to MCOs by the amount calculated under paragraph (1). Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published by the Department each year. Managed care organizations and hospitals ~~(including through their representative organizations),~~ shall develop and implement methodologies and rates for payments that will preserve and improve access to hospital services for recipients in furtherance of the State's public policy to ensure equal access to covered services to recipients under the Medical Assistance Program. The Department shall make available, on a monthly basis, a report of the capitation payments that are

made to each MCO, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection.

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

(4) As used in this subsection, "MCO" means an entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

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

(305 ILCS 5/5A-14)

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

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

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

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

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

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

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

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

(305 ILCS 5/14-12)

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

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

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

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

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

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

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

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

(7) Beginning July 1, 2014 and ending on June 30, 2020, or upon implementation of inpatient psychiatric rate

increases as described in subsection (n) of Section 5A-12.6, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(7.5) (Blank). ~~Beginning July 1, 2020, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 13%. Beginning July 1, 2022, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 13%. Beginning July 1, 2024, the reimbursement for inpatient psychiatric services shall be so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (4) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and~~

~~(9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 13%.~~

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

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

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8)and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2020, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an

amount equal to the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8), (9), (12), and (13) ~~and (9)~~ of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. ~~Beginning July 1, 2022, the statewide standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2023 the statewide standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (4) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%.~~

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

~~Beginning July 1, 2020, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on is increased by an~~

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

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

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

(12) By July 1, 2020, the Department shall, by rule, put in place reimbursement increases for inpatient services targeted to serve the purposes of ensuring equitable access to hospital services for recipients under the Medical Assistance Program by supporting hospitals in

areas of greatest health need and areas most adversely affected by health disparities. To achieve these purposes, the Department shall identify classes of hospitals to which uniform amount rate increases shall be directed. The amount shall be set so that base claims projected reimbursement is increased by an amount equal to $1,000,000,000 of the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6.

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

For purposes of this subsection, "health disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

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

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

under this subsection. The initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 3.7.

(2) The Department shall establish service specific statewide-standardized amounts to be used in the reimbursement system.

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

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

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate

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

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

(5) Beginning July 1, 2018, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less

than the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8)and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%. Beginning July 1, 2020, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8)<u>, (9), (12), and (13)</u> ~~and (9)~~ of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%. ~~Beginning July 1, 2022, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a) and paragraphs (3) and (4) of this subsection multiplied by 46%. Beginning July 1, 2023, the statewide-standardized amounts for outpatient services shall be increased by a uniform percentage so that base claims projected reimbursement is increased by an amount equal to no less than the funds allocated in paragraph (4) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of subsection (a)~~

~~and paragraphs (3) and (4) of this subsection multiplied by 46%.~~

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

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

(1) Any recalculation to the statewide-standardized amounts for outpatient services provided by hospitals that are not Critical Access

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

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

(8) The Department shall ensure that all necessary

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

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

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

payments are made to hospitals.

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

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

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

(1) Phase 1. In State fiscal years 2019 through 2020,

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

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

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

(C) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is less than 25%, the hospital transformation payment shall be equal to 50%

of the sum of its transitional hospital access payment authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(2) Phase 2. In State Fiscal Year 2021, the Department shall allocate the funds from the transitional access hospital pool in the same manner as for Phase 1 as described in paragraph (1). In addition, during State Fiscal Year 2021 the Department shall prepare and make available to hospitals data on health disparities for their use in planning improvements by which they can address negative impacts of health disparities in communities they serve. In addition, during State Fiscal Year 2021, the Department, in conjunction with the Hospital Transformation Review Committee, shall complete a stakeholder process to determine the priorities of the hospital transformation program, including at a minimum the following:

(A) The Department, in conjunction with the Hospital Transformation Review Committee, shall provide an opportunity for public input and formal mechanism for stakeholder participation in identifying priority delivery system reform and improvement purposes for the transformation program based on community health needs.

(B) The Department, in conjunction with the Hospital Transformation Review Committee, shall

conduct no fewer than 6 hearings for this purpose. No fewer than 2 of these hearings shall be held in the City of Chicago, and at least one additional hearing shall be held in another location in Cook County.

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

(3) Phase 3. During State fiscal years ~~2021 and~~ 2022 and thereafter, the Department shall ~~allocate funds from the transitional access hospital pool to create a hospital transformation pool annually and~~ make hospital transformation payments from the hospital transformation pool to hospitals participating in the transformation program. Hospitals in areas of greatest health need and areas most adversely affected by health disparities that require assistance to transform or expand their services to better meet the needs of communities they serve, as defined in rules adopted in accordance with subparagraph (B) of paragraph 4, ~~Any hospital~~ may seek transformation funding in Phase 3, however, priority shall be given to Disproportionate Share Hospitals and Critical Access Hospitals ~~2~~. Any hospital that seeks transformation funding in Phase 3 ~~2 to update or repurpose the hospital's physical structure to transition to a new delivery model,~~ must submit to the Department in writing a transformation plan, based on the Department's guidelines, that describes the changes or service expansions it seeks to make and

selects process and outcome measures, from a set developed by the Department, the hospital will meet through the course of the transformation project; a timeline for the transformation plan; as well as financial information sufficient to allow the Department to determine whether the changes or service expansions could occur but for transformation program funding. ~~desired delivery model with projections of patient volumes by service lines and projected revenues, expenses, and net income that correspond to the new delivery model.~~ In Phase 3 ~~2~~, subject to the approval of rules, the Department may use the hospital transformation pool to increase base rates, develop new adjustors, or adjust current adjustors~~, or develop new access payments~~ in order to support ~~and incentivize~~ hospitals pursuing ~~to pursue~~ such transformation. In developing such methodologies, the Department shall ensure that the entire hospital transformation pool continues to be expended to ensure access to hospital services. The Department annually shall allocate to the hospital transformation pool funds from the transitional access hospital pool as set forth in paragraph (1) plus $150,000,000 from the Hospital Provider Fund. ~~or to support organizations that had received hospital transformation payments under this Section.~~

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

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

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

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

(C) (Blank). ~~As provided in subsection (a-20) of Section 32.5 of the Emergency Medical Services (EMS)~~

~~Systems Act, a hospital that received hospital transformation payments under this Section may convert to a freestanding emergency center. To be eligible for such a conversion, the hospital must submit to the Department of Public Health certification from the Department, approved by the Hospital Transformation Review Committee, that the project is a part of the hospital's transformation.~~

(4) By March 1, 2021 ~~(3) By April 1, 2019 March 12, 2018 (Public Act 100 581)~~ the Department, in conjunction with the Hospital Transformation Review Committee, shall develop and file as an administrative rule with the Secretary of State the goals, objectives, policies, standards, payment models, process and outcome measures, or criteria to be applied in Phase 3 ~~2~~ of the program to allocate the hospital transformation funds. The goals, objectives, and policies to be considered may include, but are not limited to, reducing health disparities; achieving unmet needs of a community that a hospital serves such as behavioral health services, outpatient services, or drug rehabilitation services; attaining certain quality or patient safety benchmarks for health care services; or improving the coordination, effectiveness, and efficiency of care delivery. Notwithstanding any other provision of law, any rule adopted in accordance with this subsection (d-5) may be submitted to the Joint Committee on

Administrative Rules for approval only if the rule has first been approved by 9 of the 14 members of the Hospital Transformation Review Committee.

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

perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and rules for the hospital transformation program, the Committee shall consider and make recommendations related to qualifying criteria and payment methodologies related to safety-net hospitals and children's hospitals. Members of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary. ~~The Committee is dissolved on April 1, 2019.~~

(6) Definitions. As used in this subsection:

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

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

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

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

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under Section 5-5b.1, any updates to the system shall not result in any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors, including, but not limited

to, the number of individuals in the medical assistance program and the severity of illness of the individuals.

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

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

(j) Out-of-state hospitals. Beginning July 1, 2018, for purposes of determining for State fiscal years 2019 and 2020 the hospitals eligible for the payments authorized under subsections (a) and (b) of this Section, the Department shall

include out-of-state hospitals that are designated a Level I pediatric trauma center or a Level I trauma center by the Department of Public Health as of December 1, 2017.

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

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

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