



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

1 AN ACT concerning public aid.

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

4 Section 1. Legislative intent.

5 (1) Illinois must dedicate itself to eliminating
6 inequities in its health care system. According to a well-known
7 2019 study from the New York University School of Medicine,
8 residents of the Streeterville neighborhood of Chicago live 30
9 years longer than residents of the Englewood neighborhood on
10 average, the worst such disparity identified in the nation.

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

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

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

4 (4) The Illinois hospital assessment, a roughly
5 \$3,500,000,000 program within the Illinois Medicaid program,
6 should be used to ensure the stability, equity, and quality of
7 our health care delivery system. This means directing
8 additional Medicaid funding to hospitals in urgent need of
9 public support. Currently, the assessment awards too much
10 supplemental funding to wealthy hospitals and hospital systems
11 and not enough to hospitals dependent on the Medicaid program.

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

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

19 (210 ILCS 50/32.5)

20 Sec. 32.5. Freestanding Emergency Center.

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

1 January 1, 2015, and:

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

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

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

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

14 (B) equipment standards; and

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

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

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

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

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

6 (7) (blank);

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

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

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

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

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

26 (13) complies with any other rules adopted by the

1 Department under this Act that relate to FECs;

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

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

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

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

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

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

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

3 (a-15) Notwithstanding any other provision of this
4 Section, the Department shall issue an annual FEC license to a
5 facility if the facility: (i) discontinues operation as a
6 hospital within 180 days after December 4, 2015 (the effective
7 date of Public Act 99-490) ~~this amendatory Act of the 99th~~
8 ~~General Assembly~~ with a Health Facilities and Services Review
9 Board project number of E-017-15; (ii) has an application for a
10 permit to establish an FEC from the Health Facilities and
11 Services Review Board that is deemed complete by January 1,
12 2017; and (iii) complies with the requirements set forth in
13 paragraphs (1) through (17) of subsection (a) of this Section.

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

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

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

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

1 ~~greater than 50,000 inhabitants and shall not be subject to~~
2 ~~the requirements of the Illinois Health Facilities~~
3 ~~Planning Act that are applicable to the conversion to an~~
4 ~~FEC if the Department of Healthcare and Family Service has~~
5 ~~certified the conversion to an FEC was approved by the~~
6 ~~Hospital Transformation Review Committee as a project~~
7 ~~subject to the hospital's transformation under subsection~~
8 ~~(d 5) of Section 14 12 of the Illinois Public Aid Code; and~~
9 ~~(4) the facility is located at the same physical~~
10 ~~location where the facility served as a hospital.~~

11 (b) The Department shall:

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

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

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

1 initiated after an Emergency Suspension Order has been
2 issued; and

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

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

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

8 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

10 Sec. 5A-2. Assessment.

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

1 Procedure Act, be increased by a uniform percentage to generate
2 \$20,250,000 in the aggregate for that period from all hospitals
3 subject to the annual assessment under this paragraph.

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

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

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

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

8 ~~Subject to Sections 5A-3 and 5A-10, for State fiscal years~~
9 ~~2021 through 2024, an annual assessment on inpatient services~~
10 ~~is imposed on each hospital provider in an amount equal to~~
11 ~~\$197.19 multiplied by the difference of the hospital's occupied~~
12 ~~bed days less the hospital's Medicare bed days, provided~~
13 ~~however, that the amount of \$197.19 used to calculate the~~
14 ~~assessment under this paragraph shall, by rule, be adjusted by~~
15 ~~a uniform percentage to generate the same total annual~~
16 ~~assessment that was generated in State fiscal year 2020 from~~
17 ~~all hospitals subject to the annual assessment under this~~
18 ~~paragraph plus \$6,250,000. For State fiscal years 2021 and~~
19 ~~2022, a hospital's occupied bed days and Medicare bed days~~
20 ~~shall be determined using the most recent data available from~~
21 ~~each hospital's 2017 Medicare cost report as contained in the~~
22 ~~Healthcare Cost Report Information System file, for the quarter~~
23 ~~ending on March 31, 2019, without regard to any subsequent~~
24 ~~adjustments or changes to such data. For State fiscal years~~
25 ~~2023 and 2024, a hospital's occupied bed days and Medicare bed~~
26 ~~days shall be determined using the most recent data available~~

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

5 (b) (Blank).

6 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the
7 portion of State fiscal year 2012, beginning June 10, 2012
8 through June 30, 2012, and for State fiscal years 2013 through
9 2018, or as provided in Section 5A-16, an annual assessment on
10 outpatient services is imposed on each hospital provider in an
11 amount equal to .008766 multiplied by the hospital's outpatient
12 gross revenue, provided, however, that the amount of .008766
13 shall be increased by a uniform percentage to generate an
14 amount equal to 25% of the State share of the payments
15 authorized under Section 5A-12.5, with such increase only
16 taking effect upon the date that a State share for such
17 payments is required under federal law. For the period
18 beginning June 10, 2012 through June 30, 2012, the annual
19 assessment on outpatient services shall be prorated by
20 multiplying the assessment amount by a fraction, the numerator
21 of which is 21 days and the denominator of which is 365 days.
22 For the period of April through June 2015, the amount of
23 .008766 used to calculate the assessment under this paragraph
24 shall, by emergency rule under subsection (s) of Section 5-45
25 of the Illinois Administrative Procedure Act, be increased by a
26 uniform percentage to generate \$6,750,000 in the aggregate for

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

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

10 For the portion of State fiscal year 2012, beginning June
11 10, 2012 through June 30, 2012, and State fiscal years 2013
12 through 2018, or as provided in Section 5A-16, a hospital's
13 outpatient gross revenue shall be determined using the most
14 recent data available from each hospital's 2009 Medicare cost
15 report as contained in the Healthcare Cost Report Information
16 System file, for the quarter ending on June 30, 2011, without
17 regard to any subsequent adjustments or changes to such data.
18 If a hospital's 2009 Medicare cost report is not contained in
19 the Healthcare Cost Report Information System, then the
20 Department may obtain the hospital provider's outpatient gross
21 revenue from any source available, including, but not limited
22 to, records maintained by the hospital provider, which may be
23 inspected at all times during business hours of the day by the
24 Department or its duly authorized agents and employees.

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

1 services is imposed on each hospital provider in an amount
2 equal to .01358 multiplied by the hospital's outpatient gross
3 revenue; however, for State fiscal year 2021, the amount of
4 .01358 shall be increased by a uniform percentage to generate
5 an additional \$6,250,000 in the aggregate for that period from
6 all hospitals subject to the annual assessment under this
7 paragraph. For State fiscal years 2019 and 2020, a hospital's
8 outpatient gross revenue shall be determined using the most
9 recent data available from each hospital's 2015 Medicare cost
10 report as contained in the Healthcare Cost Report Information
11 System file, for the quarter ending on March 31, 2017, without
12 regard to any subsequent adjustments or changes to such data.
13 If a hospital's 2015 Medicare cost report is not contained in
14 the Healthcare Cost Report Information System, then the
15 Department may obtain the hospital provider's outpatient gross
16 revenue from any source available, including, but not limited
17 to, records maintained by the hospital provider, which may be
18 inspected at all times during business hours of the day by the
19 Department or its duly authorized agents and employees.
20 Notwithstanding any other provision in this Article, for a
21 hospital provider that did not have a 2015 Medicare cost
22 report, but paid an assessment in State fiscal year 2018 on the
23 basis of hypothetical data, that assessment amount shall be
24 used for State fiscal years 2019 and 2020; however, for State
25 fiscal year 2021, the assessment amount shall be increased by
26 the proportion that it represents of the total annual

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

5 ~~Subject to Sections 5A-3 and 5A-10, for State fiscal years~~
6 ~~2021 through 2024, an annual assessment on outpatient services~~
7 ~~is imposed on each hospital provider in an amount equal to~~
8 ~~.01358 multiplied by the hospital's outpatient gross revenue,~~
9 ~~provided however, that the amount of .01358 used to calculate~~
10 ~~the assessment under this paragraph shall, by rule, be adjusted~~
11 ~~by a uniform percentage to generate the same total annual~~
12 ~~assessment that was generated in State fiscal year 2020 from~~
13 ~~all hospitals subject to the annual assessment under this~~
14 ~~paragraph plus \$6,250,000. For State fiscal years 2021 and~~
15 ~~2022, a hospital's outpatient gross revenue shall be determined~~
16 ~~using the most recent data available from each hospital's 2017~~
17 ~~Medicare cost report as contained in the Healthcare Cost Report~~
18 ~~Information System file, for the quarter ending on March 31,~~
19 ~~2019, without regard to any subsequent adjustments or changes~~
20 ~~to such data. For State fiscal years 2023 and 2024, a~~
21 ~~hospital's outpatient gross revenue shall be determined using~~
22 ~~the most recent data available from each hospital's 2019~~
23 ~~Medicare cost report as contained in the Healthcare Cost Report~~
24 ~~Information System file, for the quarter ending on March 31,~~
25 ~~2021, without regard to any subsequent adjustments or changes~~
26 ~~to such data.~~

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

3 (A) For the period of July 1, 2016 through December 31,
4 2016, the product of .19125 multiplied by the sum of the
5 fee-for-service payments to hospitals as authorized under
6 Section 5A-12.5 and the adjustments authorized under
7 subsection (t) of Section 5A-12.2 to managed care
8 organizations for hospital services due and payable in the
9 month of April 2016 multiplied by 6.

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

24 (C) For the period of July 1, 2017 through December 31,
25 2017, the product of .19125 multiplied by the sum of the
26 fee-for-service payments to hospitals as authorized under

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

12 (D) For the period of January 1, 2018 through June 30,
13 2018, the product of .19125 multiplied by the sum of the
14 fee-for-service payments to hospitals as authorized under
15 Section 5A-12.5 and the adjustments authorized under
16 subsection (t) of Section 5A-12.2 to managed care
17 organizations for hospital services due and payable in the
18 month of October 2017 multiplied by 6, except that:

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

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

6 (2) The Department shall complete and apply a final
7 reconciliation of the ACA Assessment Adjustment prior to June
8 30, 2018 to account for:

9 (A) any differences between the actual payments issued
10 or scheduled to be issued prior to June 30, 2018 as
11 authorized in Section 5A-12.5 for the period of January 1,
12 2018 through June 30, 2018 and the estimated payments due
13 and payable in the month of October 2017 multiplied by 6 as
14 described in subparagraph (D); and

15 (B) any difference between the estimated
16 fee-for-service payments under subsection (b) of Section
17 5A-12.5 and the amount of such payments that are actually
18 scheduled to be paid.

19 The Department shall notify hospitals of any additional
20 amounts owed or reduction credits to be applied to the June
21 2018 ACA Assessment Adjustment. This is to be considered the
22 final reconciliation for the ACA Assessment Adjustment.

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

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

7 (4) The increases authorized under paragraph (2) of
8 subsection (a) and paragraph (2) of subsection (b-5) shall be
9 limited to the federally required State share of the total
10 payments authorized under Section 5A-12.5 if the sum of such
11 payments yields an annualized amount equal to or less than
12 \$450,000,000, or if the adjustments authorized under
13 subsection (t) of Section 5A-12.2 are found not to be
14 actuarially sound; however, this limitation shall not apply to
15 the fee-for-service payments described in subsection (b) of
16 Section 5A-12.5.

17 (c) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

18 (305 ILCS 5/5A-12.6)

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

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

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

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

20 (b) Phase in of funds to claims-based payments and updates.
21 To ensure access to hospital services, the Department may only
22 use funds financed by the assessment authorized under Section
23 5A-2 to increase claims-based payment rates, including
24 applicable policy add-on payments or adjusters, in accordance
25 with this subsection. Starting in State Fiscal Year 2021, to ~~to~~
26 increase the claims-based payment rates up to the amounts

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

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

19 (2) For State fiscal years 2021 and 2022, up to
20 \$1,696,000,000 ~~\$1,164,000,000~~ of the total spending
21 financed from the assessment authorized under Section 5A-2
22 that is intended to pay for hospital services and the
23 hospital supplemental access payments authorized under
24 subsections (d) and (f) of Section 14-12 for payment in
25 State Fiscal Year 2018 may be used to increase claims-based
26 hospital payment rates as specified under Section 14-12.

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

9 (4) (Blank). ~~For State fiscal years 2024, up to~~
10 ~~\$1,663,000,000 of the total spending financed from the~~
11 ~~assessment authorized under Section 5A-2 that is intended~~
12 ~~to pay for hospital services and the hospital supplemental~~
13 ~~access payments authorized under subsections (d) and (f) of~~
14 ~~Section 14-12 for payment in State Fiscal Year 2018 may be~~
15 ~~used to increase claims based hospital payment rates as~~
16 ~~specified under Section 14-12.~~

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

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

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

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

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

11 (d) Rate increase-based adjustment.

12 (1) From the funds financed by the assessment
13 authorized under Section 5A-2, individual funding pools by
14 category of service shall be established, for Inpatient
15 General Acute Care services in the amount of \$268,051,572,
16 Inpatient Rehab Care services in the amount of \$24,500,610,
17 Inpatient Psychiatric Care service in the amount of
18 \$94,617,812, and Outpatient Care Services in the amount of
19 \$328,828,641.

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

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

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

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

21 (A) Tier 1: A hospital with a MIUR equal to or
22 greater than 60% shall have a service credit factor of
23 200%.

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

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

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

6 (e) Graduate medical education.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 greater than the statewide mean plus 2 standard
2 deviations.

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

19 (i) Perinatal care access payment.

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

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

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

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

22 (j) Trauma care access payment.

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

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

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

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

25 (k) Perinatal and trauma center access payment.

26 (1) Each Illinois non-publicly owned hospital

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

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

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

1 greater than 25% and a calendar year 2015 occupancy ratio equal
2 to or greater than 60% shall be paid an access payment equal to
3 \$19,000,000 multiplied by a fraction, the numerator of which is
4 the hospital's Fiscal Year 2015 general acute care admissions
5 and the denominator of which is the Fiscal Year 2015 general
6 acute care admissions for all hospitals eligible under this
7 subsection for this payment.

8 (m) Small public hospital access payment.

9 (1) As used in this subsection, "small public hospital"
10 means any Illinois publicly owned hospital which is not a
11 "large public hospital" as described in 89 Ill. Adm. Code
12 148.25(a).

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

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

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

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

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

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

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

1 individuals eligible for Medicare under Title XVIII of the
2 Social Security Act (Medicaid/Medicare crossover admissions),
3 as tabulated from the Department's paid claims data for general
4 acute care admissions occurring during State fiscal year 2015
5 that was adjudicated by the Department through October 28,
6 2016.

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

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

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

1 excluding days for individuals eligible for Medicare under
2 Title XVIII of the Social Security Act (Medicaid/Medicare
3 crossover days), as tabulated from the Department's paid claims
4 data for total days occurring during State fiscal year 2015
5 that was adjudicated by the Department through October 28,
6 2016.

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

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

1 effect as of the effective date of this amendatory Act of the
2 100th General Assembly.

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

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

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

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

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

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

21 (305 ILCS 5/5A-14)

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

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

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

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

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

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

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

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

6 (305 ILCS 5/14-12)

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

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

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

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

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

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

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

20 (6) Beginning July 1, 2014 and ending on June 30, 2024,
21 in addition to the statewide-standardized amount, the
22 Department shall develop an adjustor to adjust the rate of
23 reimbursement for safety-net hospitals defined in Section
24 5-5e.1 of this Code excluding pediatric hospitals.

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

1 increases as described in subsection (n) of Section
2 5A-12.6, in addition to the statewide-standardized amount,
3 the Department shall develop an adjustor to adjust the rate
4 of reimbursement for Illinois freestanding inpatient
5 psychiatric hospitals that are not designated as
6 children's hospitals by the Department but are primarily
7 treating patients under the age of 21.

8 (7.5) (Blank). ~~Beginning July 1, 2020, the~~
9 ~~reimbursement for inpatient psychiatric services shall be~~
10 ~~so that base claims projected reimbursement is increased by~~
11 ~~an amount equal to the funds allocated in paragraph (2) of~~
12 ~~subsection (b) of Section 5A-12.6, less the amount~~
13 ~~allocated under paragraphs (8) and (9) of this subsection~~
14 ~~and paragraphs (3) and (4) of subsection (b) multiplied by~~
15 ~~13%. Beginning July 1, 2022, the reimbursement for~~
16 ~~inpatient psychiatric services shall be so that base claims~~
17 ~~projected reimbursement is increased by an amount equal to~~
18 ~~the funds allocated in paragraph (3) of subsection (b) of~~
19 ~~Section 5A-12.6, less the amount allocated under~~
20 ~~paragraphs (8) and (9) of this subsection and paragraphs~~
21 ~~(3) and (4) of subsection (b) multiplied by 13%. Beginning~~
22 ~~July 1, 2024, the reimbursement for inpatient psychiatric~~
23 ~~services shall be so that base claims projected~~
24 ~~reimbursement is increased by an amount equal to the funds~~
25 ~~allocated in paragraph (4) of subsection (b) of Section~~
26 ~~5A-12.6, less the amount allocated under paragraphs (8) and~~

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

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

10 (9) Beginning July 1, 2018, in addition to the
11 statewide-standardized amount, the Department shall apply
12 the same adjustor that is applied to trauma cases as of
13 December 31, 2017 to inpatient claims to treat patients
14 with burns, including, but not limited to, APR-DRGs 841,
15 842, 843, and 844.

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

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

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

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

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

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

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

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

1 areas of greatest health need and areas most adversely
2 affected by health disparities. To achieve these purposes,
3 the Department shall identify classes of hospitals to which
4 uniform amount rate increases shall be directed. The amount
5 shall be set so that base claims projected reimbursement is
6 increased by an amount equal to \$1,000,000,000 of the funds
7 allocated in paragraph (2) of subsection (b) of Section
8 5A-12.6.

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

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

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

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

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

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

7 (A) The initial statewide standardized amounts,
8 with the labor portion adjusted by the Calendar Year
9 2013 Medicare Outpatient Prospective Payment System
10 wage index with reclassifications, shall be published
11 by the Department on its website no later than 10
12 calendar days prior to their effective date.

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

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

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

10 (4) Beginning July 1, 2018, in addition to the
11 statewide standardized amounts, the Department shall make
12 an add-on payment for outpatient expensive devices and
13 drugs. This add-on payment shall at least apply to claim
14 lines that: (i) are assigned with one of the following
15 EAPGs: 490, 1001 to 1020, and coded with one of the
16 following revenue codes: 0274 to 0276, 0278; or (ii) are
17 assigned with one of the following EAPGs: 430 to 441, 443,
18 444, 460 to 465, 495, 496, 1090. The add-on payment shall
19 be calculated as follows: the claim line's covered charges
20 multiplied by the hospital's total acute cost to charge
21 ratio, less the claim line's EAPG payment plus \$1,000,
22 multiplied by 0.8.

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

1 than the funds allocated in paragraph (1) of subsection (b)
2 of Section 5A-12.6, less the amount allocated under
3 paragraphs (8) and (9) of subsection (a) and paragraphs (3)
4 and (4) of this subsection multiplied by 46%. Beginning
5 July 1, 2020, the statewide-standardized amounts for
6 outpatient services shall be increased by a uniform
7 percentage so that base claims projected reimbursement is
8 increased by an amount equal to no less than the funds
9 allocated in paragraph (2) of subsection (b) of Section
10 5A-12.6, less the amount allocated under paragraphs (8),
11 (9), (12), and (13) ~~and (9)~~ of subsection (a) and
12 paragraphs (3) and (4) of this subsection multiplied by
13 46%. ~~Beginning July 1, 2022, the statewide-standardized~~
14 ~~amounts for outpatient services shall be increased by a~~
15 ~~uniform percentage so that base claims projected~~
16 ~~reimbursement is increased by an amount equal to the funds~~
17 ~~allocated in paragraph (3) of subsection (b) of Section~~
18 ~~5A 12.6, less the amount allocated under paragraphs (8) and~~
19 ~~(9) of subsection (a) and paragraphs (3) and (4) of this~~
20 ~~subsection multiplied by 46%. Beginning July 1, 2023, the~~
21 ~~statewide-standardized amounts for outpatient services~~
22 ~~shall be increased by a uniform percentage so that base~~
23 ~~claims projected reimbursement is increased by an amount~~
24 ~~equal to no less than the funds allocated in paragraph (4)~~
25 ~~of subsection (b) of Section 5A-12.6, less the amount~~
26 ~~allocated under paragraphs (8) and (9) of subsection (a)~~

1 ~~and paragraphs (3) and (4) of this subsection multiplied by~~
2 ~~46%.~~

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

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

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

1 Hospitals shall be the amount necessary to achieve the
2 increase in the statewide-standardized amounts for
3 outpatient services increased by a uniform percentage,
4 so that base claims projected reimbursement is
5 increased by an amount equal to no less than the funds
6 allocated in paragraph (1) of subsection (b) of Section
7 5A-12.6, less the amount allocated under paragraphs
8 (8), (9), (12), and (13) ~~and (9)~~ of subsection (a) and
9 paragraphs (3) and (4) of this subsection, for all
10 hospitals that are not Critical Access Hospitals,
11 multiplied by 46%.

12 (2) It is the intent of the General Assembly that
13 the recalculations required under this paragraph (7)
14 by Public Act 100-1181 ~~this amendatory Act of the 100th~~
15 ~~General Assembly~~ shall be applied prospectively to
16 claims for dates of service provided on or after March
17 8, 2019 (the effective date of Public Act 100-1181)
18 ~~this amendatory Act of the 100th General Assembly~~ and
19 that no recoupment or repayment by the Department or an
20 MCO of payments attributable to recalculation under
21 this paragraph (7), issued to the hospital for dates of
22 service on or after July 1, 2018 and before March 8,
23 2019 (the effective date of Public Act 100-1181) ~~this~~
24 ~~amendatory Act of the 100th General Assembly~~, shall be
25 permitted.

26 (8) The Department shall ensure that all necessary

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

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

18 (d) Transition period. There shall be a transition period
19 to the reimbursement systems authorized under this Section that
20 shall begin on the effective date of these systems and continue
21 until June 30, 2018, unless extended by rule by the Department.
22 To help provide an orderly and predictable transition to the
23 new reimbursement systems and to preserve and enhance access to
24 the hospital services during this transition, the Department
25 shall allocate a transitional hospital access pool of at least
26 \$290,000,000 annually so that transitional hospital access

1 payments are made to hospitals.

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

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

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

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

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

11 (A) If the hospital's Rate Year 2017 Medicaid
12 inpatient utilization rate is equal to or greater than
13 45%, the hospital transformation payment shall be
14 equal to 100% of the sum of its transitional hospital
15 access payment authorized under subsection (d) and any
16 supplemental payment authorized under subsection (f).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 (4) By March 1, 2021 ~~(3) By April 1, 2019~~ ~~March 12,~~
10 ~~2018 (Public Act 100-581)~~ the Department, in conjunction
11 with the Hospital Transformation Review Committee, shall
12 develop and file as an administrative rule with the
13 Secretary of State the goals, objectives, policies,
14 standards, payment models, process and outcome measures,
15 or criteria to be applied in Phase 3 ~~2~~ of the program to
16 allocate the hospital transformation funds. The goals,
17 objectives, and policies to be considered may include, but
18 are not limited to, reducing health disparities; achieving
19 unmet needs of a community that a hospital serves such as
20 behavioral health services, outpatient services, or drug
21 rehabilitation services; attaining certain quality or
22 patient safety benchmarks for health care services; or
23 improving the coordination, effectiveness, and efficiency
24 of care delivery. Notwithstanding any other provision of
25 law, any rule adopted in accordance with this subsection
26 (d-5) may be submitted to the Joint Committee on

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

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

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

17 (6) Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

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

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

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

8 (Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19;
9 101-81, eff. 7-12-19; revised 7-29-19.)

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