HB4808

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4808

by Rep. Kimberly Du Buclet

SYNOPSIS AS INTRODUCED:

305 ILCS 5/14-12

Amends the Hospital Services Trust Fund Article in the Illinois Public Aid Code. In provisions concerning annual funding for the health care transformation program, provides that funds that had been budgeted but unexpended in State fiscal years 2021 through 2027 may be allocated in State fiscal year 2028 in an amount not to exceed $150,000,000.

LRB104 19092 KTG 32537 b

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 14-12 as follows:

(305 ILCS 5/14-12)

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

(a) Inpatient hospital services. Effective on and after the effective date of this amendatory Act of the 104th General Assembly, reimbursement for inpatient general acute care services shall utilize the All Patient Refined Diagnosis Related Grouping (APR-DRG) software distributed by Solventum™ previously known as 3M™ Health Information System. Solventum™ shall be the exclusive provider of this software unless the Department determines that Solventum™ is unable to meet the required operational or contractual terms. Only under these circumstances may an alternative authorized provider of the software be considered.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. Initial weighting factors shall be

1 the weighting factors as published by the authorized
2 provider of this software adjusted for the Illinois
3 experience.
4 (2) The Department shall establish a
5 statewide-standardized amount to be used in the inpatient
6 reimbursement system. The Department shall publish these
7 amounts on its website no later than 10 calendar days
8 prior to their effective date.
9 (3) In addition to the statewide-standardized amount,
10 the Department shall develop adjusters to adjust the rate
11 of reimbursement for critical Medicaid providers or
12 services for trauma, transplantation services, perinatal
13 care, and Graduate Medical Education (GME).
14 (4) The Department shall develop add-on payments to
15 account for exceptionally costly inpatient stays,
16 consistent with Medicare outlier principles. Outlier fixed
17 loss thresholds may be updated to control for excessive
18 growth in outlier payments no more frequently than on an
19 annual basis, but at least once every 4 years. Upon
20 updating the fixed loss thresholds, the Department shall
21 be required to update base rates within 12 months.
22 (5) The Department shall define those hospitals or
23 distinct parts of hospitals that shall be exempt from the
24 APR-DRG reimbursement system established under this
25 Section. The Department shall publish these hospitals'
26 inpatient rates on its website no later than 10 calendar

1 days prior to their effective date.
2 (6) Beginning July 1, 2014 and ending on December 31,
3 2023, in addition to the statewide-standardized amount,
4 the Department shall develop an adjustor to adjust the
5 rate of reimbursement for safety-net hospitals defined in
6 Section 5-5e.1 of this Code excluding pediatric hospitals.
7 (7) Beginning July 1, 2014, in addition to the
8 statewide-standardized amount, the Department shall
9 develop an adjustor to adjust the rate of reimbursement
10 for Illinois freestanding inpatient psychiatric hospitals
11 that are not designated as children's hospitals by the
12 Department but are primarily treating patients under the
13 age of 21.
14 (7.5) (Blank).
15 (8) Beginning July 1, 2018, in addition to the
16 statewide-standardized amount, the Department shall adjust
17 the rate of reimbursement for hospitals designated by the
18 Department of Public Health as a Perinatal Level II or II+
19 center by applying the same adjustor that is applied to
20 Perinatal and Obstetrical care cases for Perinatal Level
21 III centers, as of December 31, 2017.
22 (9) Beginning July 1, 2018, in addition to the
23 statewide-standardized amount, the Department shall apply
24 the same adjustor that is applied to trauma cases as of
25 December 31, 2017 to inpatient claims to treat patients
26 with burns, including, but not limited to, APR-DRGs 841,

1 842, 843, and 844.
2 (10) Beginning July 1, 2018, the
3 statewide-standardized amount for inpatient general acute
4 care services shall be uniformly increased so that base
5 claims projected reimbursement is increased by an amount
6 equal to the funds allocated in paragraph (1) of
7 subsection (b) of Section 5A-12.6, less the amount
8 allocated under paragraphs (8) and (9) of this subsection
9 and paragraphs (3) and (4) of subsection (b) multiplied by
10 40%.
11 (11) Beginning July 1, 2018, the reimbursement for
12 inpatient rehabilitation services shall be increased by
13 the addition of a $96 per day add-on.
14 (b) Outpatient hospital services. Effective on and after
15 the effective date of this amendatory Act of the 104th General
16 Assembly, reimbursement for outpatient services shall utilize
17 the Enhanced Ambulatory Procedure Grouping (EAPG) software
18 distributed by Solventum™ previously known as 3M™ Health
19 Information System. Solventum™ shall be the exclusive
20 provider of this software unless the Agency determines that
21 Solventum™ is unable to meet the required operational or
22 contractual terms. Only under these circumstances may an
23 alternative authorized provider of the software be considered.
24 (1) The Department shall establish Medicaid weighting
25 factors to be used in the reimbursement system established
26 under this subsection. The initial weighting factors shall

1 be the weighting factors as published by the authorized
2 provider.
3 (2) The Department shall establish service specific
4 statewide-standardized amounts to be used in the
5 reimbursement system.
6 (A) The initial statewide standardized amounts,
7 with the labor portion adjusted by the Calendar Year
8 2013 Medicare Outpatient Prospective Payment System
9 wage index with reclassifications, shall be published
10 by the Department on its website no later than 10
11 calendar days prior to their effective date.
12 (B) The Department shall establish adjustments to
13 the statewide-standardized amounts for each Critical
14 Access Hospital, as designated by the Department of
15 Public Health in accordance with 42 CFR 485, Subpart
16 F. For outpatient services provided on or before June
17 30, 2018, the EAPG standardized amounts are determined
18 separately for each critical access hospital such that
19 simulated EAPG payments using outpatient base period
20 paid claim data plus payments under Section 5A-12.4 of
21 this Code net of the associated tax costs are equal to
22 the estimated costs of outpatient base period claims
23 data with a rate year cost inflation factor applied.
24 (3) In addition to the statewide-standardized amounts,
25 the Department shall develop adjusters to adjust the rate
26 of reimbursement for critical Medicaid hospital outpatient

1 providers or services, including outpatient high volume or
2 safety-net hospitals. Beginning July 1, 2018, the
3 outpatient high volume adjustor shall be increased to
4 increase annual expenditures associated with this adjustor
5 by $79,200,000, based on the State Fiscal Year 2015 base
6 year data and this adjustor shall apply to public
7 hospitals, except for large public hospitals, as defined
8 under 89 Ill. Adm. Code 148.25(a).
9 (4) Beginning July 1, 2018, in addition to the
10 statewide standardized amounts, the Department shall make
11 an add-on payment for outpatient expensive devices and
12 drugs. This add-on payment shall at least apply to claim
13 lines that: (i) are assigned with one of the following
14 EAPGs: 490, 1001 to 1020, and coded with one of the
15 following revenue codes: 0274 to 0276, 0278; or (ii) are
16 assigned with one of the following EAPGs: 430 to 441, 443,
17 444, 460 to 465, 495, 496, 1090. The add-on payment shall
18 be calculated as follows: the claim line's covered charges
19 multiplied by the hospital's total acute cost to charge
20 ratio, less the claim line's EAPG payment plus $1,000,
21 multiplied by 0.8.
22 (5) Beginning July 1, 2018, the statewide-standardized
23 amounts for outpatient services shall be increased by a
24 uniform percentage so that base claims projected
25 reimbursement is increased by an amount equal to no less
26 than the funds allocated in paragraph (1) of subsection

1 (b) of Section 5A-12.6, less the amount allocated under
2 paragraphs (8) and (9) of subsection (a) and paragraphs
3 (3) and (4) of this subsection multiplied by 46%.
4 (6) Effective for dates of service on or after July 1,
5 2018, the Department shall establish adjustments to the
6 statewide-standardized amounts for each Critical Access
7 Hospital, as designated by the Department of Public Health
8 in accordance with 42 CFR 485, Subpart F, such that each
9 Critical Access Hospital's standardized amount for
10 outpatient services shall be increased by the applicable
11 uniform percentage determined pursuant to paragraph (5) of
12 this subsection. It is the intent of the General Assembly
13 that the adjustments required under this paragraph (6) by
14 Public Act 100-1181 shall be applied retroactively to
15 claims for dates of service provided on or after July 1,
16 2018.
17 (7) Effective for dates of service on or after March
18 8, 2019 (the effective date of Public Act 100-1181), 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
7 Section 5A-12.6, less the amount allocated under
8 paragraphs (8) 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 shall be applied prospectively
15 to claims for dates of service provided on or after
16 March 8, 2019 (the effective date of Public Act
17 100-1181) and that no recoupment or repayment by the
18 Department or an MCO of payments attributable to
19 recalculation under this paragraph (7), issued to the
20 hospital for dates of service on or after July 1, 2018
21 and before March 8, 2019 (the effective date of Public
22 Act 100-1181), shall be permitted.

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

1 and applied retroactively in accordance with Section
2 5-30.8 of this Code within 90 days of March 8, 2019 (the
3 effective date of Public Act 100-1181).
4 (9) Within 60 days after federal approval of the
5 change made to the assessment in Section 5A-2 by Public
6 Act 101-650, the Department shall incorporate into the
7 EAPG system for outpatient services those services
8 performed by hospitals currently billed through the
9 Non-Institutional Provider billing system.
10 (b-5) Notwithstanding any other provision of this Section,
11 beginning with dates of service on and after January 1, 2023,
12 any general acute care hospital with more than 500 outpatient
13 psychiatric Medicaid services to persons under 19 years of age
14 in any calendar year shall be paid the outpatient add-on
15 payment of no less than $113.
16 (c) In consultation with the hospital community, the
17 Department is authorized to replace 89 Ill. Adm. Code 152.150
18 as published in 38 Ill. Reg. 4980 through 4986 within 12 months
19 of June 16, 2014 (the effective date of Public Act 98-651). If
20 the Department does not replace these rules within 12 months
21 of June 16, 2014 (the effective date of Public Act 98-651), the
22 rules in effect for 152.150 as published in 38 Ill. Reg. 4980
23 through 4986 shall remain in effect until modified by rule by
24 the Department. Nothing in this subsection shall be construed
25 to mandate that the Department file a replacement rule.
26 (d) Transition period. There shall be a transition period

1 to the reimbursement systems authorized under this Section
2 that shall begin on the effective date of these systems and
3 continue until June 30, 2018, unless extended by rule by the
4 Department. To help provide an orderly and predictable
5 transition to the new reimbursement systems and to preserve
6 and enhance access to the hospital services during this
7 transition, the Department shall allocate a transitional
8 hospital access pool of at least $290,000,000 annually so that
9 transitional hospital access payments are made to hospitals.

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

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

24 (d-5) Hospital and health care transformation program. The
25 Department shall develop a hospital and health care
26 transformation program to provide financial assistance to

hospitals in transforming their services and care models to better align with the needs of the communities they serve. The payments authorized in this Section shall be subject to approval by the federal government.

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

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

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

1 subsection (d) and any supplemental payment authorized
2 under subsection (f).
3 (C) If the hospital's Rate Year 2017 Medicaid
4 inpatient utilization rate is less than 25%, the
5 hospital transformation payment shall be equal to 50%
6 of the sum of its transitional hospital access payment
7 authorized under subsection (d) and any supplemental
8 payment authorized under subsection (f).
9 (2) Phase 2.
10 (A) The funding amount from phase one shall be
11 incorporated into directed payment and pass-through
12 payment methodologies described in Section 5A-12.7.
13 (B) Because there are communities in Illinois that
14 experience significant health care disparities due to
15 systemic racism, as recently emphasized by the
16 COVID-19 pandemic, aggravated by social determinants
17 of health and a lack of sufficiently allocated health
18 care resources, particularly community-based services,
19 preventive care, obstetric care, chronic disease
20 management, and specialty care, the Department shall
21 establish a health care transformation program that
22 shall be supported by the transformation funding pool.
23 It is the intention of the General Assembly that
24 innovative partnerships funded by the pool must be
25 designed to establish or improve integrated health
26 care delivery systems that will provide significant

access to the Medicaid and uninsured populations in their communities, as well as improve health care equity. It is also the intention of the General Assembly that partnerships recognize and address the disparities revealed by the COVID-19 pandemic, as well as the need for post-COVID care. During State fiscal years 2021 through 2027, the hospital and health care transformation program shall be supported by an annual transformation funding pool of up to $150,000,000, pending federal matching funds, to be allocated during the specified fiscal years for the purpose of facilitating hospital and health care transformation. Funds that had been budgeted but unexpended in State fiscal years 2021 through 2027 may be allocated in State fiscal year 2028 in an amount not to exceed $150,000,000. No disbursement of moneys for transformation projects from the transformation funding pool described under this Section shall be considered an award, a grant, or an expenditure of grant funds. Funding agreements made in accordance with the transformation program shall be considered purchases of care under the Illinois Procurement Code, and funds shall be expended by the Department in a manner that maximizes federal funding to expend the entire allocated amount.

The Department shall convene, within 30 days after

1 March 12, 2021 (the effective date of Public Act
2 101-655), a workgroup that includes subject matter
3 experts on health care disparities and stakeholders
4 from distressed communities, which could be a
5 subcommittee of the Medicaid Advisory Committee, to
6 review and provide recommendations on how Department
7 policy, including health care transformation, can
8 improve health disparities and the impact on
9 communities disproportionately affected by COVID-19.
10 The workgroup shall consider and make recommendations
11 on the following issues: a community safety-net
12 designation of certain hospitals, racial equity, and a
13 regional partnership to bring additional specialty
14 services to communities.

15 (C) As provided in paragraph (9) of Section 3 of
16 the Illinois Health Facilities Planning Act, any
17 hospital participating in the transformation program
18 may be excluded from the requirements of the Illinois
19 Health Facilities Planning Act for those projects
20 related to the hospital's transformation. To be
21 eligible, the hospital must submit to the Health
22 Facilities and Services Review Board approval from the
23 Department that the project is a part of the
24 hospital's transformation.

25 (D) As provided in subsection (a-20) of Section
26 32.5 of the Emergency Medical Services (EMS) Systems

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

8 (E) Criteria for proposals. To be eligible for
9 funding under this Section, a transformation proposal
10 shall meet all of the following criteria:

11 (i) the proposal shall be designed based on
12 community needs assessment completed by either a
13 University partner or other qualified entity with
14 significant community input;

15 (ii) the proposal shall be a collaboration
16 among providers across the care and community
17 spectrum, including preventative care, primary
18 care specialty care, hospital services, mental
19 health and substance abuse services, as well as
20 community-based entities that address the social
21 determinants of health;

22 (iii) the proposal shall be specifically
23 designed to improve health care outcomes and
24 reduce health care disparities, and improve the
25 coordination, effectiveness, and efficiency of
26 care delivery;

1 (iv) the proposal shall have specific
2 measurable metrics related to disparities that
3 will be tracked by the Department and made public
4 by the Department;
5 (v) the proposal shall include a commitment to
6 include Business Enterprise Program certified
7 vendors or other entities controlled and managed
8 by minorities or women; and
9 (vi) the proposal shall specifically increase
10 access to primary, preventive, or specialty care.
11 (F) Entities eligible to be funded.
12 (i) Proposals for funding should come from
13 collaborations operating in one of the most
14 distressed communities in Illinois as determined
15 by the U.S. Centers for Disease Control and
16 Prevention's Social Vulnerability Index for
17 Illinois and areas disproportionately impacted by
18 COVID-19 or from rural areas of Illinois.
19 (ii) The Department shall prioritize
20 partnerships from distressed communities, which
21 include Business Enterprise Program certified
22 vendors or other entities controlled and managed
23 by minorities or women and also include one or
24 more of the following: safety-net hospitals,
25 critical access hospitals, the campuses of
26 hospitals that have closed since January 1, 2018,

1 or other health care providers designed to address
2 specific health care disparities, including the
3 impact of COVID-19 on individuals and the
4 community and the need for post-COVID care. All
5 funded proposals must include specific measurable
6 goals and metrics related to improved outcomes and
7 reduced disparities which shall be tracked by the
8 Department.
9 (iii) The Department should target the funding
10 in the following ways: $30,000,000 of
11 transformation funds to projects that are a
12 collaboration between a safety-net hospital,
13 particularly community safety-net hospitals, and
14 other providers and designed to address specific
15 health care disparities, $20,000,000 of
16 transformation funds to collaborations between
17 safety-net hospitals and a larger hospital partner
18 that increases specialty care in distressed
19 communities, $30,000,000 of transformation funds
20 to projects that are a collaboration between
21 hospitals and other providers in distressed areas
22 of the State designed to address specific health
23 care disparities, $15,000,000 to collaborations
24 between critical access hospitals and other
25 providers designed to address specific health care
26 disparities, and $15,000,000 to cross-provider

1 collaborations designed to address specific health
2 care disparities, and $5,000,000 to collaborations
3 that focus on workforce development.
4 (iv) The Department may allocate up to
5 $5,000,000 for planning, racial equity analysis,
6 or consulting resources for the Department or
7 entities without the resources to develop a plan
8 to meet the criteria of this Section. Any contract
9 for consulting services issued by the Department
10 under this subparagraph shall comply with the
11 provisions of Section 5-45 of the State Officials
12 and Employees Ethics Act. Based on availability of
13 federal funding, the Department may directly
14 procure consulting services or provide funding to
15 the collaboration. The provision of resources
16 under this subparagraph is not a guarantee that a
17 project will be approved.
18 (v) The Department shall take steps to ensure
19 that safety-net hospitals operating in
20 under-resourced communities receive priority
21 access to hospital and health care transformation
22 funds, including consulting funds, as provided
23 under this Section.
24 (G) Process for submitting and approving projects
25 for distressed communities. The Department shall issue
26 a template for application. The Department shall post

1 any proposal received on the Department's website for
2 at least 2 weeks for public comment, and any such
3 public comment shall also be considered in the review
4 process. Applicants may request that proprietary
5 financial information be redacted from publicly posted
6 proposals and the Department in its discretion may
7 agree. Proposals for each distressed community must
8 include all of the following:

9 (i) A detailed description of how the project
10 intends to affect the goals outlined in this
11 subsection, describing new interventions, new
12 technology, new structures, and other changes to
13 the health care delivery system planned.

14 (ii) A detailed description of the racial and
15 ethnic makeup of the entities' board and
16 leadership positions and the salaries of the
17 executive staff of entities in the partnership
18 that is seeking to obtain funding under this
19 Section.

20 (iii) A complete budget, including an overall
21 timeline and a detailed pathway to sustainability
22 within a 5-year period, specifying other sources
23 of funding, such as in-kind, cost-sharing, or
24 private donations, particularly for capital needs.
25 There is an expectation that parties to the
26 transformation project dedicate resources to the

1 extent they are able and that these expectations
2 are delineated separately for each entity in the
3 proposal.

4 (iv) A description of any new entities formed
5 or other legal relationships between collaborating
6 entities and how funds will be allocated among
7 participants.

8 (v) A timeline showing the evolution of sites
9 and specific services of the project over a 5-year
10 period, including services available to the
11 community by site.

12 (vi) Clear milestones indicating progress
13 toward the proposed goals of the proposal as
14 checkpoints along the way to continue receiving
15 funding. The Department is authorized to refine
16 these milestones in agreements, and is authorized
17 to impose reasonable penalties, including
18 repayment of funds, for substantial lack of
19 progress.

20 (vii) A clear statement of the level of
21 commitment the project will include for minorities
22 and women in contracting opportunities, including
23 as equity partners where applicable, or as
24 subcontractors and suppliers in all phases of the
25 project.

26 (viii) If the community study utilized is not

1 the study commissioned and published by the
2 Department, the applicant must define the
3 methodology used, including documentation of clear
4 community participation.
5 (ix) A description of the process used in
6 collaborating with all levels of government in the
7 community served in the development of the
8 project, including, but not limited to,
9 legislators and officials of other units of local
10 government.
11 (x) Documentation of a community input process
12 in the community served, including links to
13 proposal materials on public websites.
14 (xi) Verifiable project milestones and quality
15 metrics that will be impacted by transformation.
16 These project milestones and quality metrics must
17 be identified with improvement targets that must
18 be met.
19 (xii) Data on the number of existing employees
20 by various job categories and wage levels by the
21 zip code of the employees' residence and
22 benchmarks for the continued maintenance and
23 improvement of these levels. The proposal must
24 also describe any retraining or other workforce
25 development planned for the new project.
26 (xiii) If a new entity is created by the

1 project, a description of how the board will be
2 reflective of the community served by the
3 proposal.

4 (xiv) An explanation of how the proposal will
5 address the existing disparities that exacerbated
6 the impact of COVID-19 and the need for post-COVID
7 care in the community, if applicable.

8 (xv) An explanation of how the proposal is
9 designed to increase access to care, including
10 specialty care based upon the community's needs.

11 (H) The Department shall evaluate proposals for
12 compliance with the criteria listed under subparagraph
13 (G). Proposals meeting all of the criteria may be
14 eligible for funding with the areas of focus
15 prioritized as described in item (ii) of subparagraph
16 (F). Based on the funds available, the Department may
17 negotiate funding agreements with approved applicants
18 to maximize federal funding. Nothing in this
19 subsection requires that an approved project be funded
20 to the level requested. Agreements shall specify the
21 amount of funding anticipated annually, the
22 methodology of payments, the limit on the number of
23 years such funding may be provided, and the milestones
24 and quality metrics that must be met by the projects in
25 order to continue to receive funding during each year
26 of the program. Agreements shall specify the terms and

1 conditions under which a health care facility that
2 receives funds under a purchase of care agreement and
3 closes in violation of the terms of the agreement must
4 pay an early closure fee no greater than 50% of the
5 funds it received under the agreement, prior to the
6 Health Facilities and Services Review Board
7 considering an application for closure of the
8 facility. Any project that is funded shall be required
9 to provide quarterly written progress reports, in a
10 form prescribed by the Department, and at a minimum
11 shall include the progress made in achieving any
12 milestones or metrics or Business Enterprise Program
13 commitments in its plan. The Department may reduce or
14 end payments, as set forth in transformation plans, if
15 milestones or metrics or Business Enterprise Program
16 commitments are not achieved. The Department shall
17 seek to make payments from the transformation fund in
18 a manner that is eligible for federal matching funds.
19 In reviewing the proposals, the Department shall
20 take into account the needs of the community, data
21 from the study commissioned by the Department from the
22 University of Illinois-Chicago if applicable, feedback
23 from public comment on the Department's website, as
24 well as how the proposal meets the criteria listed
25 under subparagraph (G). Alignment with the
26 Department's overall strategic initiatives shall be an

1 important factor. To the extent that fiscal year
2 funding is not adequate to fund all eligible projects
3 that apply, the Department shall prioritize
4 applications that most comprehensively and effectively
5 address the criteria listed under subparagraph (G).
6 (3) (Blank).
7 (4) Hospital Transformation Review Committee. There is
8 created the Hospital Transformation Review Committee. The
9 Committee shall consist of 14 members. No later than 30
10 days after March 12, 2018 (the effective date of Public
11 Act 100-581), the 4 legislative leaders shall each appoint
12 3 members; the Governor shall appoint the Director of
13 Healthcare and Family Services, or his or her designee, as
14 a member; and the Director of Healthcare and Family
15 Services shall appoint one member. Any vacancy shall be
16 filled by the applicable appointing authority within 15
17 calendar days. The members of the Committee shall select a
18 Chair and a Vice-Chair from among its members, provided
19 that the Chair and Vice-Chair cannot be appointed by the
20 same appointing authority and must be from different
21 political parties. The Chair shall have the authority to
22 establish a meeting schedule and convene meetings of the
23 Committee, and the Vice-Chair shall have the authority to
24 convene meetings in the absence of the Chair. The
25 Committee may establish its own rules with respect to
26 meeting schedule, notice of meetings, and the disclosure

of documents; however, the Committee shall not have the power to subpoena individuals or documents and any rules must be approved by 9 of the 14 members. The Committee shall perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and rules for the hospital and health care transformation program, the Committee shall consider and make recommendations related to qualifying criteria and payment methodologies related to safety-net hospitals and children's hospitals. Members of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary. The Committee is dissolved on April 1, 2019.

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

1 (f) Continuation of supplemental payments. Any
2 supplemental payments authorized under 89 Illinois
3 Administrative Code 148 effective January 1, 2014 and that
4 continue during the period of July 1, 2014 through December
5 31, 2014 shall remain in effect as long as the assessment
6 imposed by Section 5A-2 that is in effect on December 31, 2017
7 remains in effect.
8 (g) Notwithstanding subsections (a) through (f) of this
9 Section and notwithstanding the changes authorized under
10 Section 5-5b.1, any updates to the system shall not result in
11 any diminishment of the overall effective rates of
12 reimbursement as of the implementation date of the new system
13 (July 1, 2014). These updates shall not preclude variations in
14 any individual component of the system or hospital rate
15 variations. Nothing in this Section shall prohibit the
16 Department from increasing the rates of reimbursement or
17 developing payments to ensure access to hospital services.
18 Nothing in this Section shall be construed to guarantee a
19 minimum amount of spending in the aggregate or per hospital as
20 spending may be impacted by factors, including, but not
21 limited to, the number of individuals in the medical
22 assistance program and the severity of illness of the
23 individuals.
24 (h) The Department shall have the authority to modify by
25 rulemaking any changes to the rates or methodologies in this
26 Section as required by the federal government to obtain

1 federal financial participation for expenditures made under
2 this Section.
3 (i) Except for subsections (g) and (h) of this Section,
4 the Department shall, pursuant to subsection (c) of Section
5 5-40 of the Illinois Administrative Procedure Act, provide for
6 presentation at the June 2014 hearing of the Joint Committee
7 on Administrative Rules (JCAR) additional written notice to
8 JCAR of the following rules in order to commence the second
9 notice period for the following rules: rules published in the
10 Illinois Register, rule dated February 21, 2014 at 38 Ill.
11 Reg. 4559 (Medical Payment), 4628 (Specialized Health Care
12 Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic
13 Related Grouping (DRG) Prospective Payment System (PPS)), and
14 4977 (Hospital Reimbursement Changes), and published in the
15 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499
16 (Specialized Health Care Delivery Systems) and 6505 (Hospital
17 Services).
18 (j) Out-of-state hospitals. Beginning July 1, 2018, for
19 purposes of determining for State fiscal years 2019 and 2020
20 and subsequent fiscal years the hospitals eligible for the
21 payments authorized under subsections (a) and (b) of this
22 Section, the Department shall include out-of-state hospitals
23 that are designated a Level I pediatric trauma center or a
24 Level I trauma center by the Department of Public Health as of
25 December 1, 2017.
26 (k) The Department shall notify each hospital and managed

1 care organization, in writing, of the impact of the updates
2 under this Section at least 30 calendar days prior to their
3 effective date.

4 (l) This Section is subject to Section 14-12.5.

5 (Source: P.A. 103-102, eff. 6-16-23; 103-154, eff. 6-30-23;
6 104-9, eff. 6-16-25; 104-417, eff. 8-15-25.)