



Rep. Gregory Harris

Filed: 5/21/2020

10100SB2541ham001

LRB101 18248 KTG 72312 a

1 AMENDMENT TO SENATE BILL 2541

2 AMENDMENT NO. _____. Amend Senate Bill 2541 by replacing
3 everything after the enacting clause with the following:

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

6 (5 ILCS 100/5-45.1 new)

7 Sec. 5-45.1. Emergency rulemaking. To provide for the
8 expeditious and timely implementation of changes made to
9 Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code by
10 this amendatory Act of the 101st General Assembly, emergency
11 rules may be adopted in accordance with Section 5-45 by the
12 respective Department. The 24-month limitation on the adoption
13 of emergency rules does not apply to rules adopted under this
14 Section. The adoption of emergency rules authorized by Section
15 5-45 and this Section is deemed to be necessary for the public
16 interest, safety, and welfare.

1 This Section is repealed on January 1, 2026.

2 (5 ILCS 100/5-46.3 rep.)

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

5 Section 15. The Illinois Health Facilities Planning Act is
6 amended by changing Sections 3 and 8.7 as follows:

7 (20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

8 (Section scheduled to be repealed on December 31, 2029)

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

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

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

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

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

20 (A) If a demonstration project under the Nursing
21 Home Care Act applies for a certificate of need to
22 convert to a nursing facility, it shall meet the
23 licensure and certificate of need requirements in

1 effect as of the date of application.

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

6 (3.5) Skilled and intermediate care facilities
7 licensed under the ID/DD Community Care Act or the MC/DD
8 Act. No permit or exemption is required for a facility
9 licensed under the ID/DD Community Care Act or the MC/DD
10 Act prior to the reduction of the number of beds at a
11 facility. If there is a total reduction of beds at a
12 facility licensed under the ID/DD Community Care Act or the
13 MC/DD Act, this is a discontinuation or closure of the
14 facility. If a facility licensed under the ID/DD Community
15 Care Act or the MC/DD Act reduces the number of beds or
16 discontinues the facility, that facility must notify the
17 Board as provided in Section 14.1 of this Act.

18 (3.7) Facilities licensed under the Specialized Mental
19 Health Rehabilitation Act of 2013.

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

24 (5) Kidney disease treatment centers, including a
25 free-standing hemodialysis unit required to meet the
26 requirements of 42 CFR 494 in order to be certified for

1 participation in Medicare and Medicaid under Titles XVIII
2 and XIX of the federal Social Security Act.

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

7 (B) This Act does not apply to a dialysis unit
8 located in a licensed nursing home that offers or
9 provides dialysis-related services to residents with
10 end stage renal disease who have elected to receive
11 home dialysis within the nursing home.

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

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

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

26 (8) An institution, place, building, or room housing

1 major medical equipment used in the direct clinical
2 diagnosis or treatment of patients, and whose project cost
3 is in excess of the capital expenditure minimum.

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

6 (1) Federally-owned facilities.

7 (2) Facilities used solely for healing by prayer or
8 spiritual means.

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

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

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

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

1 demonstration program.

2 (7) The closure of an entity or a portion of an entity
3 licensed under the Nursing Home Care Act, the Specialized
4 Mental Health Rehabilitation Act of 2013, the ID/DD
5 Community Care Act, or the MC/DD Act, with the exception of
6 facilities operated by a county or Illinois Veterans Homes,
7 that elect to convert, in whole or in part, to an assisted
8 living or shared housing establishment licensed under the
9 Assisted Living and Shared Housing Act and with the
10 exception of a facility licensed under the Specialized
11 Mental Health Rehabilitation Act of 2013 in connection with
12 a proposal to close a facility and re-establish the
13 facility in another location.

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

23 (9) (Blank). ~~Any project the Department of Healthcare~~
24 ~~and Family Services certifies was approved by the Hospital~~
25 ~~Transformation Review Committee as a project subject to the~~
26 ~~hospital's transformation under subsection (d 5) of~~

1 ~~Section 14-12 of the Illinois Public Aid Code, provided the~~
2 ~~hospital shall submit the certification to the Board.~~
3 ~~Nothing in this paragraph excludes a health care facility~~
4 ~~from the requirements of this Act after the approved~~
5 ~~transformation project is complete. All other requirements~~
6 ~~under this Act continue to apply. Hospitals that are not~~
7 ~~subject to this Act under this paragraph shall notify the~~
8 ~~Health Facilities and Services Review Board within 30 days~~
9 ~~of the dates that bed changes or service changes occur.~~

10 With the exception of those health care facilities
11 specifically included in this Section, nothing in this Act
12 shall be intended to include facilities operated as a part of
13 the practice of a physician or other licensed health care
14 professional, whether practicing in his individual capacity or
15 within the legal structure of any partnership, medical or
16 professional corporation, or unincorporated medical or
17 professional group. Further, this Act shall not apply to
18 physicians or other licensed health care professional's
19 practices where such practices are carried out in a portion of
20 a health care facility under contract with such health care
21 facility by a physician or by other licensed health care
22 professionals, whether practicing in his individual capacity
23 or within the legal structure of any partnership, medical or
24 professional corporation, or unincorporated medical or
25 professional groups, unless the entity constructs, modifies,
26 or establishes a health care facility as specifically defined

1 in this Section. This Act shall apply to construction or
2 modification and to establishment by such health care facility
3 of such contracted portion which is subject to facility
4 licensing requirements, irrespective of the party responsible
5 for such action or attendant financial obligation.

6 "Person" means any one or more natural persons, legal
7 entities, governmental bodies other than federal, or any
8 combination thereof.

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

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

21 "Construction or modification" means the establishment,
22 erection, building, alteration, reconstruction, modernization,
23 improvement, extension, discontinuation, change of ownership,
24 of or by a health care facility, or the purchase or acquisition
25 by or through a health care facility of equipment or service
26 for diagnostic or therapeutic purposes or for facility

1 administration or operation, or any capital expenditure made by
2 or on behalf of a health care facility which exceeds the
3 capital expenditure minimum; however, any capital expenditure
4 made by or on behalf of a health care facility for (i) the
5 construction or modification of a facility licensed under the
6 Assisted Living and Shared Housing Act or (ii) a conversion
7 project undertaken in accordance with Section 30 of the Older
8 Adult Services Act shall be excluded from any obligations under
9 this Act.

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

13 "Major medical equipment" means medical equipment which is
14 used for the provision of medical and other health services and
15 which costs in excess of the capital expenditure minimum,
16 except that such term does not include medical equipment
17 acquired by or on behalf of a clinical laboratory to provide
18 clinical laboratory services if the clinical laboratory is
19 independent of a physician's office and a hospital and it has
20 been determined under Title XVIII of the Social Security Act to
21 meet the requirements of paragraphs (10) and (11) of Section
22 1861(s) of such Act. In determining whether medical equipment
23 has a value in excess of the capital expenditure minimum, the
24 value of studies, surveys, designs, plans, working drawings,
25 specifications, and other activities essential to the
26 acquisition of such equipment shall be included.

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

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

1 to review.

2 "Capital expenditure minimum" means \$11,500,000 for
3 projects by hospital applicants, \$6,500,000 for applicants for
4 projects related to skilled and intermediate care long-term
5 care facilities licensed under the Nursing Home Care Act, and
6 \$3,000,000 for projects by all other applicants, which shall be
7 annually adjusted to reflect the increase in construction costs
8 due to inflation, for major medical equipment and for all other
9 capital expenditures.

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

15 "Non-clinical service area" means an area (i) for the
16 benefit of the patients, visitors, staff, or employees of a
17 health care facility and (ii) not directly related to the
18 diagnosis, treatment, or rehabilitation of persons receiving
19 services from the health care facility. "Non-clinical service
20 areas" include, but are not limited to, chapels; gift shops;
21 news stands; computer systems; tunnels, walkways, and
22 elevators; telephone systems; projects to comply with life
23 safety codes; educational facilities; student housing;
24 patient, employee, staff, and visitor dining areas;
25 administration and volunteer offices; modernization of
26 structural components (such as roof replacement and masonry

1 work); boiler repair or replacement; vehicle maintenance and
2 storage facilities; parking facilities; mechanical systems for
3 heating, ventilation, and air conditioning; loading docks; and
4 repair or replacement of carpeting, tile, wall coverings,
5 window coverings or treatments, or furniture. Solely for the
6 purpose of this definition, "non-clinical service area" does
7 not include health and fitness centers.

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

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

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

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

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

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

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

3 "Out-of-state facility" means a person that is both (i)
4 licensed as a hospital or as an ambulatory surgery center under
5 the laws of another state or that qualifies as a hospital or an
6 ambulatory surgery center under regulations adopted pursuant
7 to the Social Security Act and (ii) not licensed under the
8 Ambulatory Surgical Treatment Center Act, the Hospital
9 Licensing Act, or the Nursing Home Care Act. Affiliates of
10 out-of-state facilities shall be considered out-of-state
11 facilities. Affiliates of Illinois licensed health care
12 facilities 100% owned by an Illinois licensed health care
13 facility, its parent, or Illinois physicians licensed to
14 practice medicine in all its branches shall not be considered
15 out-of-state facilities. Nothing in this definition shall be
16 construed to include an office or any part of an office of a
17 physician licensed to practice medicine in all its branches in
18 Illinois that is not required to be licensed under the
19 Ambulatory Surgical Treatment Center Act.

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

26 "Related person" means any person that: (i) is at least 50%

1 owned, directly or indirectly, by either the health care
2 facility or a person owning, directly or indirectly, at least
3 50% of the health care facility; or (ii) owns, directly or
4 indirectly, at least 50% of the health care facility.

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

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

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

24 "State Board Staff Report" means the document that sets
25 forth the review and findings of the State Board staff, as
26 prescribed by the State Board, regarding applications subject

1 to Board jurisdiction.

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

4 (20 ILCS 3960/8.7)

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

6 Sec. 8.7. Application for permit for discontinuation of a
7 health care facility or category of service; public notice and
8 public hearing.

9 (a) Upon a finding that an application to close a health
10 care facility or discontinue a category of service is complete,
11 the State Board shall publish a legal notice on 3 consecutive
12 days in a newspaper of general circulation in the area or
13 community to be affected and afford the public an opportunity
14 to request a hearing. If the application is for a facility
15 located in a Metropolitan Statistical Area, an additional legal
16 notice shall be published in a newspaper of limited
17 circulation, if one exists, in the area in which the facility
18 is located. If the newspaper of limited circulation is
19 published on a daily basis, the additional legal notice shall
20 be published on 3 consecutive days. The legal notice shall also
21 be posted on the Health Facilities and Services Review Board's
22 website and sent to the State Representative and State Senator
23 of the district in which the health care facility is located.
24 In addition, the health care facility shall provide notice of
25 closure to the local media that the health care facility would

1 routinely notify about facility events.

2 An application to close a health care facility shall only
3 be deemed complete if it includes evidence that the health care
4 facility provided written notice at least 30 days prior to
5 filing the application of its intent to do so to the
6 municipality in which it is located, the State Representative
7 and State Senator of the district in which the health care
8 facility is located, the State Board, the Director of Public
9 Health, and the Director of Healthcare and Family Services. The
10 changes made to this subsection by this amendatory Act of the
11 101st General Assembly shall apply to all applications
12 submitted after the effective date of this amendatory Act of
13 the 101st General Assembly.

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

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

26 (d) The changes made to this Section by this amendatory Act

1 of the 101st General Assembly shall apply to all applications
2 submitted after the effective date of this amendatory Act of
3 the 101st General Assembly.

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

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

7 (30 ILCS 105/6z-81)

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

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

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

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

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

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

4 (c) The Fund shall consist of the following:

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

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

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

16 (3.5) Proceeds from the assessment authorized under
17 Article V-H of the Illinois Public Aid Code.

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

20 (5) All federal matching funds received by the Illinois
21 Department of Healthcare and Family Services as a result of
22 expenditures made by the Department for Medical Assistance
23 from the General Revenue Fund, the Tobacco Settlement
24 Recovery Fund, the Long-Term Care Provider Fund, and the
25 Drug Rebate Fund related to individuals eligible for
26 medical assistance pursuant to the Patient Protection and

1 Affordable Care Act (P.L. 111-148) and Section 5-2 of the
2 Illinois Public Aid Code.

3 (d) In addition to any other transfers that may be provided
4 for by law, on the effective date of Public Act 97-44, or as
5 soon thereafter as practical, the State Comptroller shall
6 direct and the State Treasurer shall transfer the sum of
7 \$365,000,000 from the General Revenue Fund into the Healthcare
8 Provider Relief Fund.

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

14 (f) Notwithstanding any other State law to the contrary,
15 and in addition to any other transfers that may be provided for
16 by law, the State Comptroller shall order transferred and the
17 State Treasurer shall transfer \$500,000,000 to the Healthcare
18 Provider Relief Fund from the General Revenue Fund in equal
19 monthly installments of \$100,000,000, with the first transfer
20 to be made on July 1, 2012, or as soon thereafter as practical,
21 and with each of the remaining transfers to be made on August
22 1, 2012, September 1, 2012, October 1, 2012, and November 1,
23 2012, or as soon thereafter as practical. This transfer may
24 assist the Department of Healthcare and Family Services in
25 improving Medical Assistance bill processing timeframes or in
26 meeting the possible requirements of Senate Bill 3397, or other

1 similar legislation, of the 97th General Assembly should it
2 become law.

3 (g) Notwithstanding any other State law to the contrary,
4 and in addition to any other transfers that may be provided for
5 by law, on July 1, 2013, or as soon thereafter as may be
6 practical, the State Comptroller shall direct and the State
7 Treasurer shall transfer the sum of \$601,000,000 from the
8 General Revenue Fund to the Healthcare Provider Relief Fund.

9 (Source: P.A. 100-587, eff. 6-4-18; 101-9, eff. 6-5-19; revised
10 7-17-19.)

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

13 (210 ILCS 50/32.5)

14 Sec. 32.5. Freestanding Emergency Center.

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

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

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

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

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

8 (B) equipment standards; and

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

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

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

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

26 (7) (blank);

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

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

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

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

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

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

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

24 (15) submits a copy of the permit issued by the Health
25 Facilities and Services Review Board indicating that the
26 facility has complied with the Illinois Health Facilities

1 Planning Act with respect to the health services to be
2 provided at the facility;

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

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

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

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

23 (a-15) Notwithstanding any other provision of this
24 Section, the Department shall issue an annual FEC license to a
25 facility if the facility: (i) discontinues operation as a
26 hospital within 180 days after December 4, 2015 (the effective

1 date of Public Act 99-490) ~~this amendatory Act of the 99th~~
2 ~~General Assembly~~ with a Health Facilities and Services Review
3 Board project number of E-017-15; (ii) has an application for a
4 permit to establish an FEC from the Health Facilities and
5 Services Review Board that is deemed complete by January 1,
6 2017; and (iii) complies with the requirements set forth in
7 paragraphs (1) through (17) of subsection (a) of this Section.

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

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

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

19 (3) the facility complies with the requirements set
20 forth in paragraphs (1) through (17), provided however that
21 the FEC may be located in a municipality with a population
22 greater than 50,000 inhabitants and shall not be subject to
23 the requirements of the Illinois Health Facilities
24 Planning Act that are applicable to the conversion to an
25 FEC if the Department of Healthcare and Family Services
26 ~~Service~~ has approved ~~certified~~ the conversion to an FEC ~~was~~

1 ~~approved by the Hospital Transformation Review Committee~~
2 as a project subject to the hospital's transformation under
3 subsection (d-5) of Section 14-12 of the Illinois Public
4 Aid Code; and

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

7 (b) The Department shall:

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

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

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

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

26 (Source: P.A. 99-490, eff. 12-4-15; 99-710, eff. 8-5-16;

1 100-581, eff. 3-12-18; revised 7-23-19.)

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

6 (305 ILCS 5/5-5.05c new)

7 Sec. 5-5.05c. Access to physician services. The Department
8 shall increase rates of reimbursement for physician services to
9 as close to 60% of Medicare rates in effect as of January 1,
10 2020 utilizing the rates of Illinois Locality 99 facility
11 rates.

12 (305 ILCS 5/5-5e.1)

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

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

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

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

20 (3) meets one of the following:

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

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

1 (b) Definitions. As used in this Section:

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

7 (2) "MIUR" means Medicaid Inpatient Utilization Rate
8 and is defined as a fraction, the numerator of which is the
9 number of a hospital's inpatient days provided in the
10 hospital's fiscal year ending 3 years prior to the rate
11 year, to patients who, for such days, were eligible for
12 Medicaid under Title XIX of the federal Social Security
13 Act, 42 USC 1396a et seq., excluding those persons eligible
14 for medical assistance pursuant to 42 U.S.C.
15 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
16 Section 5-2 of this Article, and the denominator of which
17 is the total number of the hospital's inpatient days in
18 that same period, excluding those persons eligible for
19 medical assistance pursuant to 42 U.S.C.
20 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
21 Section 5-2 of this Article.

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

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

26 (c) Beginning July 1, 2012 and ending on December 31, 2022

1 ~~June 30, 2020~~, a hospital that would have qualified for the
2 rate year beginning October 1, 2011, shall be a Safety-Net
3 Hospital.

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

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

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

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

16 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

18 Sec. 5A-2. Assessment.

19 (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal
20 years 2009 through 2018, or as long as continued under Section
21 5A-16, an annual assessment on inpatient services is imposed on
22 each hospital provider in an amount equal to \$218.38 multiplied
23 by the difference of the hospital's occupied bed days less the
24 hospital's Medicare bed days, provided, however, that the
25 amount of \$218.38 shall be increased by a uniform percentage to

1 generate an amount equal to 75% of the State share of the
2 payments authorized under Section 5A-12.5, with such increase
3 only taking effect upon the date that a State share for such
4 payments is required under federal law. For the period of April
5 through June 2015, the amount of \$218.38 used to calculate the
6 assessment under this paragraph shall, by emergency rule under
7 subsection (s) of Section 5-45 of the Illinois Administrative
8 Procedure Act, be increased by a uniform percentage to generate
9 \$20,250,000 in the aggregate for that period from all hospitals
10 subject to the annual assessment under this paragraph.

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

19 For State fiscal years 2009 through 2018, or as provided in
20 Section 5A-16, a hospital's occupied bed days and Medicare bed
21 days shall be determined using the most recent data available
22 from each hospital's 2005 Medicare cost report as contained in
23 the Healthcare Cost Report Information System file, for the
24 quarter ending on December 31, 2006, without regard to any
25 subsequent adjustments or changes to such data. If a hospital's
26 2005 Medicare cost report is not contained in the Healthcare

1 Cost Report Information System, then the Illinois Department
2 may obtain the hospital provider's occupied bed days and
3 Medicare bed days from any source available, including, but not
4 limited to, records maintained by the hospital provider, which
5 may be inspected at all times during business hours of the day
6 by the Illinois Department or its duly authorized agents and
7 employees.

8 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
9 fiscal years 2019 and 2020, an annual assessment on inpatient
10 services is imposed on each hospital provider in an amount
11 equal to \$197.19 multiplied by the difference of the hospital's
12 occupied bed days less the hospital's Medicare bed days~~+~~
13 ~~however, for State fiscal year 2021, the amount of \$197.19~~
14 ~~shall be increased by a uniform percentage to generate an~~
15 ~~additional \$6,250,000 in the aggregate for that period from all~~
16 ~~hospitals subject to the annual assessment under this~~
17 ~~paragraph.~~ For State fiscal years 2019 and 2020, a hospital's
18 occupied bed days and Medicare bed days shall be determined
19 using the most recent data available from each hospital's 2015
20 Medicare cost report as contained in the Healthcare Cost Report
21 Information System file, for the quarter ending on March 31,
22 2017, without regard to any subsequent adjustments or changes
23 to such data. If a hospital's 2015 Medicare cost report is not
24 contained in the Healthcare Cost Report Information System,
25 then the Illinois Department may obtain the hospital provider's
26 occupied bed days and Medicare bed days from any source

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

15 (4) Subject to Sections 5A-3 and 5A-10, for the period of
16 July 1, 2020 through December 31, 2020 and calendar ~~State~~
17 ~~fiscal~~ years 2021 and 2022 through ~~2024~~, an annual assessment
18 on inpatient services is imposed on each hospital provider in
19 an amount equal to \$221.50 ~~\$197.19~~ multiplied by the difference
20 of the hospital's occupied bed days less the hospital's
21 Medicare bed days, provided however: for the period of July 1,
22 2020 through December 31, 2020, (i) the assessment shall be
23 equal to 50% of the annual amount; and (ii) the amount of
24 \$221.50 shall be retroactively adjusted by a uniform percentage
25 to generate an amount equal to 50% of the Assessment
26 Adjustment, as defined in subsection (b-7), ~~that the amount of~~

1 ~~\$197.19 used to calculate the assessment under this paragraph~~
2 ~~shall, by rule, be adjusted by a uniform percentage to generate~~
3 ~~the same total annual assessment that was generated in State~~
4 ~~fiscal year 2020 from all hospitals subject to the annual~~
5 ~~assessment under this paragraph plus \$6,250,000. For the period~~
6 ~~of July 1, 2020 through December 31, 2020 and calendar State~~
7 ~~fiscal years 2021 and 2022, a hospital's occupied bed days and~~
8 Medicare bed days shall be determined using the most recent
9 data available from each hospital's 2015 ~~2017~~ Medicare cost
10 report as contained in the Healthcare Cost Report Information
11 System file, for the quarter ending on March 31, 2017 ~~2019~~,
12 without regard to any subsequent adjustments or changes to such
13 data. If a hospital's 2015 Medicare cost report is not
14 contained in the Healthcare Cost Report Information System,
15 then the Illinois Department may obtain the hospital provider's
16 occupied bed days and Medicare bed days from any source
17 available, including, but not limited to, records maintained by
18 the hospital provider, which may be inspected at all times
19 during business hours of the day by the Illinois Department or
20 its duly authorized agents and employees. Should the change in
21 the assessment methodology for fiscal years 2021 through
22 December 31, 2022 not be approved on or before June 30, 2020,
23 the assessment and payments under this Article in effect for
24 fiscal year 2020 shall remain in place until the new assessment
25 is approved. If the assessment methodology for July 1, 2020
26 through December 31, 2022, is approved on or after July 1,

1 2020, it shall be retroactive to July 1, 2020, subject to
2 federal approval and provided that the payments authorized
3 under Section 5A-12.7 have the same effective date as the new
4 assessment methodology. In giving retroactive effect to the
5 assessment approved after June 30, 2020, credit toward the new
6 assessment shall be given for any payments of the previous
7 assessment for periods after June 30, 2020. Notwithstanding any
8 other provision of this Article, for a hospital provider that
9 did not have a 2015 Medicare cost report, but paid an
10 assessment in State Fiscal Year 2020 on the basis of
11 hypothetical data, the data that was the basis for the 2020
12 assessment shall be used to calculate the assessment under this
13 paragraph. For State fiscal years 2023 and 2024, a hospital's
14 occupied bed days and Medicare bed days shall be determined
15 using the most recent data available from each hospital's 2019
16 Medicare cost report as contained in the Healthcare Cost Report
17 Information System file, for the quarter ending on March 31,
18 2021, without regard to any subsequent adjustments or changes
19 to such data.

20 (b) (Blank).

21 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the
22 portion of State fiscal year 2012, beginning June 10, 2012
23 through June 30, 2012, and for State fiscal years 2013 through
24 2018, or as provided in Section 5A-16, an annual assessment on
25 outpatient services is imposed on each hospital provider in an
26 amount equal to .008766 multiplied by the hospital's outpatient

1 gross revenue, provided, however, that the amount of .008766
2 shall be increased by a uniform percentage to generate an
3 amount equal to 25% of the State share of the payments
4 authorized under Section 5A-12.5, with such increase only
5 taking effect upon the date that a State share for such
6 payments is required under federal law. For the period
7 beginning June 10, 2012 through June 30, 2012, the annual
8 assessment on outpatient services shall be prorated by
9 multiplying the assessment amount by a fraction, the numerator
10 of which is 21 days and the denominator of which is 365 days.
11 For the period of April through June 2015, the amount of
12 .008766 used to calculate the assessment under this paragraph
13 shall, by emergency rule under subsection (s) of Section 5-45
14 of the Illinois Administrative Procedure Act, be increased by a
15 uniform percentage to generate \$6,750,000 in the aggregate for
16 that period from all hospitals subject to the annual assessment
17 under this paragraph.

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

25 For the portion of State fiscal year 2012, beginning June
26 10, 2012 through June 30, 2012, and State fiscal years 2013

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

14 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
15 fiscal years 2019 and 2020, an annual assessment on outpatient
16 services is imposed on each hospital provider in an amount
17 equal to .01358 multiplied by the hospital's outpatient gross
18 revenue; ~~however, for State fiscal year 2021, the amount of~~
19 ~~.01358 shall be increased by a uniform percentage to generate~~
20 ~~an additional \$6,250,000 in the aggregate for that period from~~
21 ~~all hospitals subject to the annual assessment under this~~
22 ~~paragraph.~~ For State fiscal years 2019 and 2020, a hospital's
23 outpatient gross revenue shall be determined using the most
24 recent data available from each hospital's 2015 Medicare cost
25 report as contained in the Healthcare Cost Report Information
26 System file, for the quarter ending on March 31, 2017, without

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

20 (4) Subject to Sections 5A-3 and 5A-10, for the period of
21 July 1, 2020 through December 31, 2020 and calendar State
22 fiscal years 2021 and 2022 through 2024, an annual assessment
23 on outpatient services is imposed on each hospital provider in
24 an amount equal to .01525 ~~-.01358~~ multiplied by the hospital's
25 outpatient gross revenue, provided however: (i) for the period
26 of July 1, 2020 through December 31, 2020, the assessment shall

1 be equal to 50% of the annual amount; and (ii) the amount of
2 .01525 shall be retroactively adjusted by a uniform percentage
3 to generate an amount equal to 50% of the Assessment
4 Adjustment, as defined in subsection (b-7), that the amount of
5 .01358 used to calculate the assessment under this paragraph
6 shall, by rule, be adjusted by a uniform percentage to generate
7 the same total annual assessment that was generated in State
8 fiscal year 2020 from all hospitals subject to the annual
9 assessment under this paragraph plus \$6,250,000. For the period
10 of July 1, 2020 through December 31, 2020 and calendar State
11 fiscal years 2021 and 2022, a hospital's outpatient gross
12 revenue shall be determined using the most recent data
13 available from each hospital's 2015 2017 Medicare cost report
14 as contained in the Healthcare Cost Report Information System
15 file, for the quarter ending on March 31, 2017 2019, without
16 regard to any subsequent adjustments or changes to such data.
17 If a hospital's 2015 Medicare cost report is not contained in
18 the Healthcare Cost Report Information System, then the
19 Illinois Department may obtain the hospital provider's
20 outpatient revenue data from any source available, including,
21 but not limited to, records maintained by the hospital
22 provider, which may be inspected at all times during business
23 hours of the day by the Illinois Department or its duly
24 authorized agents and employees. Should the change in the
25 assessment methodology above for fiscal years 2021 through
26 calendar year 2022 not be approved prior to July 1, 2020, the

1 assessment and payments under this Article in effect for fiscal
2 year 2020 shall remain in place until the new assessment is
3 approved. If the change in the assessment methodology above for
4 July 1, 2020 through December 31, 2022, is approved after June
5 30, 2020, it shall have a retroactive effective date of July 1,
6 2020, subject to federal approval and provided that the
7 payments authorized under Section 12A-7 have the same effective
8 date as the new assessment methodology. In giving retroactive
9 effect to the assessment approved after June 30, 2020, credit
10 toward the new assessment shall be given for any payments of
11 the previous assessment for periods after June 30, 2020.
12 Notwithstanding any other provision of this Article, for a
13 hospital provider that did not have a 2015 Medicare cost
14 report, but paid an assessment in State Fiscal Year 2020 on the
15 basis of hypothetical data, the data that was the basis for the
16 2020 assessment shall be used to calculate the assessment under
17 this paragraph. For State fiscal years 2023 and 2024, a
18 hospital's outpatient gross revenue shall be determined using
19 the most recent data available from each hospital's 2019
20 Medicare cost report as contained in the Healthcare Cost Report
21 Information System file, for the quarter ending on March 31,
22 2021, without regard to any subsequent adjustments or changes
23 to such data.

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

26 (A) For the period of July 1, 2016 through December 31,

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

7 (B) For the period of January 1, 2017 through June 30,
8 2017, the product of .19125 multiplied by the sum of the
9 fee-for-service payments to hospitals as authorized under
10 Section 5A-12.5 and the adjustments authorized under
11 subsection (t) of Section 5A-12.2 to managed care
12 organizations for hospital services due and payable in the
13 month of October 2016 multiplied by 6, except that the
14 amount calculated under this subparagraph (B) shall be
15 adjusted, either positively or negatively, to account for
16 the difference between the actual payments issued under
17 Section 5A-12.5 for the period beginning July 1, 2016
18 through December 31, 2016 and the estimated payments due
19 and payable in the month of April 2016 multiplied by 6 as
20 described in subparagraph (A).

21 (C) For the period of July 1, 2017 through December 31,
22 2017, the product of .19125 multiplied by the sum of the
23 fee-for-service payments to hospitals as authorized under
24 Section 5A-12.5 and the adjustments authorized under
25 subsection (t) of Section 5A-12.2 to managed care
26 organizations for hospital services due and payable in the

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

9 (D) For the period of January 1, 2018 through June 30,
10 2018, the product of .19125 multiplied by the sum of the
11 fee-for-service payments to hospitals as authorized under
12 Section 5A-12.5 and the adjustments authorized under
13 subsection (t) of Section 5A-12.2 to managed care
14 organizations for hospital services due and payable in the
15 month of October 2017 multiplied by 6, except that:

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

24 (ii) the amount calculated under this subparagraph
25 (D) shall be adjusted to include the product of .19125
26 multiplied by the sum of the fee-for-service payments,

1 if any, estimated to be paid to hospitals under
2 subsection (b) of Section 5A-12.5.

3 (2) The Department shall complete and apply a final
4 reconciliation of the ACA Assessment Adjustment prior to June
5 30, 2018 to account for:

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

12 (B) any difference between the estimated
13 fee-for-service payments under subsection (b) of Section
14 5A-12.5 and the amount of such payments that are actually
15 scheduled to be paid.

16 The Department shall notify hospitals of any additional
17 amounts owed or reduction credits to be applied to the June
18 2018 ACA Assessment Adjustment. This is to be considered the
19 final reconciliation for the ACA Assessment Adjustment.

20 (3) Notwithstanding any other provision of this Section, if
21 for any reason the scheduled payments under subsection (b) of
22 Section 5A-12.5 are not issued in full by the final day of the
23 period authorized under subsection (b) of Section 5A-12.5,
24 funds collected from each hospital pursuant to subparagraph (D)
25 of paragraph (1) and pursuant to paragraph (2), attributable to
26 the scheduled payments authorized under subsection (b) of

1 Section 5A-12.5 that are not issued in full by the final day of
2 the period attributable to each payment authorized under
3 subsection (b) of Section 5A-12.5, shall be refunded.

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

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

16 (A) For the period of July 1, 2020 through December 31,
17 2020, the product of .3853 multiplied by the total of the
18 actual payments made under subsections (c) through (k) of
19 Section 5A-12.7 attributable to the period, less the total
20 of the assessment imposed under subsections (a) and (b-5)
21 of this Section for the period.

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

1 (a) and (b-5) of this Section for the period.

2 (2) The Department shall calculate and notify each hospital
3 of the total Assessment Adjustment and any additional
4 assessment owed by the hospital or refund owed to the hospital
5 on either a semi-annual or annual basis. Such notice shall be
6 issued at least 30 days prior to any period in which the
7 assessment will be adjusted. Any additional assessment owed by
8 the hospital or refund owed to the hospital shall be uniformly
9 applied to the assessment owed by the hospital in monthly
10 installments for the subsequent semi-annual period or calendar
11 year. If no assessment is owed in the subsequent year, any
12 amount owed by the hospital or refund due to the hospital,
13 shall be paid in a lump sum.

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

19 (c) (Blank).

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

25 (e) Notwithstanding any other provision of this Section,
26 any plan providing for an assessment on a hospital provider as

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

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

25 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

2 (a) The assessment imposed by Section 5A-2 for State fiscal
3 year 2009 through State fiscal year 2018 or as provided in
4 Section 5A-16, shall be due and payable in monthly
5 installments, each equaling one-twelfth of the assessment for
6 the year, on the fourteenth State business day of each month.
7 No installment payment of an assessment imposed by Section 5A-2
8 shall be due and payable, however, until after the Comptroller
9 has issued the payments required under this Article.

10 Except as provided in subsection (a-5) of this Section, the
11 assessment imposed by subsection (b-5) of Section 5A-2 for the
12 portion of State fiscal year 2012 beginning June 10, 2012
13 through June 30, 2012, and for State fiscal year 2013 through
14 State fiscal year 2018 or as provided in Section 5A-16, shall
15 be due and payable in monthly installments, each equaling
16 one-twelfth of the assessment for the year, on the 17th State
17 business day of each month. No installment payment of an
18 assessment imposed by subsection (b-5) of Section 5A-2 shall be
19 due and payable, however, until after: (i) the Department
20 notifies the hospital provider, in writing, that the payment
21 methodologies to hospitals required under Section 5A-12.4,
22 have been approved by the Centers for Medicare and Medicaid
23 Services of the U.S. Department of Health and Human Services,
24 and the waiver under 42 CFR 433.68 for the assessment imposed
25 by subsection (b-5) of Section 5A-2, if necessary, has been
26 granted by the Centers for Medicare and Medicaid Services of

1 the U.S. Department of Health and Human Services; and (ii) the
2 Comptroller has issued the payments required under Section
3 5A-12.4. Upon notification to the Department of approval of the
4 payment methodologies required under Section 5A-12.4 and the
5 waiver granted under 42 CFR 433.68, if necessary, all
6 installments otherwise due under subsection (b-5) of Section
7 5A-2 prior to the date of notification shall be due and payable
8 to the Department upon written direction from the Department
9 and issuance by the Comptroller of the payments required under
10 Section 5A-12.4.

11 Except as provided in subsection (a-5) of this Section, the
12 assessment imposed under Section 5A-2 for State fiscal year
13 2019 and each subsequent State fiscal year shall be due and
14 payable in monthly installments, each equaling one-twelfth of
15 the assessment for the year, on the 17th State business day of
16 each month. The Department has discretion to establish a later
17 date due to delays in payments being made to hospitals as
18 required under Section 5A-12.7. No installment payment of an
19 assessment imposed by Section 5A-2 shall be due and payable,
20 however, until after: (i) the Department notifies the hospital
21 provider, in writing, that the payment methodologies to
22 hospitals required under Section 5A-12.6 or 5A-12.7 have been
23 approved by the Centers for Medicare and Medicaid Services of
24 the U.S. Department of Health and Human Services, and the
25 waiver under 42 CFR 433.68 for the assessment imposed by
26 Section 5A-2, if necessary, has been granted by the Centers for

1 Medicare and Medicaid Services of the U.S. Department of Health
2 and Human Services; and (ii) the Comptroller and managed care
3 organizations have ~~has~~ issued the payments required under
4 Section 5A-12.6 or 5A-12.7. Upon notification to the Department
5 of approval of the payment methodologies required under Section
6 5A-12.6 or 5A-12.7 and the waiver granted under 42 CFR 433.68,
7 if necessary, all installments otherwise due under Section 5A-2
8 prior to the date of notification shall be due and payable to
9 the Department upon written direction from the Department and
10 issuance by the Comptroller and managed care organizations of
11 the payments required under Section 5A-12.6 or 5A-12.7.

12 (a-5) The Illinois Department may accelerate the schedule
13 upon which assessment installments are due and payable by
14 hospitals with a payment ratio greater than or equal to one.
15 Such acceleration of due dates for payment of the assessment
16 may be made only in conjunction with a corresponding
17 acceleration in access payments identified in Section 5A-12.2,
18 Section 5A-12.4, ~~or~~ Section 5A-12.6, or Section 5A-12.7 to the
19 same hospitals. For the purposes of this subsection (a-5), a
20 hospital's payment ratio is defined as the quotient obtained by
21 dividing the total payments for the State fiscal year, as
22 authorized under Section 5A-12.2, Section 5A-12.4, ~~or~~ Section
23 5A-12.6, or Section 5A-12.7, by the total assessment for the
24 State fiscal year imposed under Section 5A-2 or subsection
25 (b-5) of Section 5A-2.

26 (b) The Illinois Department is authorized to establish

1 delayed payment schedules for hospital providers that are
2 unable to make installment payments when due under this Section
3 due to financial difficulties, as determined by the Illinois
4 Department.

5 (c) If a hospital provider fails to pay the full amount of
6 an installment when due (including any extensions granted under
7 subsection (b)), there shall, unless waived by the Illinois
8 Department for reasonable cause, be added to the assessment
9 imposed by Section 5A-2 a penalty assessment equal to the
10 lesser of (i) 5% of the amount of the installment not paid on
11 or before the due date plus 5% of the portion thereof remaining
12 unpaid on the last day of each 30-day period thereafter or (ii)
13 100% of the installment amount not paid on or before the due
14 date. For purposes of this subsection, payments will be
15 credited first to unpaid installment amounts (rather than to
16 penalty or interest), beginning with the most delinquent
17 installments.

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

25 (Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19;
26 101-209, eff. 8-5-19.)

1 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

2 Sec. 5A-8. Hospital Provider Fund.

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

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

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

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

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

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

4 (5) For making transfers, as those transfers are
 5 authorized in the proceedings authorizing debt under the
 6 Short Term Borrowing Act, but transfers made under this
 7 paragraph (5) shall not exceed the principal amount of debt
 8 issued in anticipation of the receipt by the State of
 9 moneys to be deposited into the Fund.

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

16 (6.5) For making transfers to the Healthcare Provider
 17 Relief Fund, except that transfers made under this
 18 paragraph (6.5) shall not exceed \$60,000,000 in the
 19 aggregate.

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

23	Health and Human Services Medicaid Trust	
24	Fund	\$20,000,000
25	Long-Term Care Provider Fund	\$30,000,000
26	General Revenue Fund	\$80,000,000.

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

5 (7.1) (Blank).

6 (7.5) (Blank).

7 (7.8) (Blank).

8 (7.9) (Blank).

9 (7.10) For State fiscal year 2014, for making transfers
10 of the moneys resulting from the assessment under
11 subsection (b-5) of Section 5A-2 and received from hospital
12 providers under Section 5A-4 and transferred into the
13 Hospital Provider Fund under Section 5A-6 to the designated
14 funds not exceeding the following amounts in that State
15 fiscal year:

16 Healthcare Provider Relief Fund \$100,000,000

17 Transfers under this paragraph shall be made within 7
18 days after the payments have been received pursuant to the
19 schedule of payments provided in subsection (a) of Section
20 5A-4.

21 The additional amount of transfers in this paragraph
22 (7.10), authorized by Public Act 98-651, shall be made
23 within 10 State business days after June 16, 2014 (the
24 effective date of Public Act 98-651). That authority shall
25 remain in effect even if Public Act 98-651 does not become
26 law until State fiscal year 2015.

1 (7.10a) For State fiscal years 2015 through 2018, for
2 making transfers of the moneys resulting from the
3 assessment under subsection (b-5) of Section 5A-2 and
4 received from hospital providers under Section 5A-4 and
5 transferred into the Hospital Provider Fund under Section
6 5A-6 to the designated funds not exceeding the following
7 amounts related to each State fiscal year:

8 Healthcare Provider Relief Fund \$50,000,000

9 Transfers under this paragraph shall be made within 7
10 days after the payments have been received pursuant to the
11 schedule of payments provided in subsection (a) of Section
12 5A-4.

13 (7.11) (Blank).

14 (7.12) For State fiscal year 2013, for increasing by
15 21/365ths the transfer of the moneys resulting from the
16 assessment under subsection (b-5) of Section 5A-2 and
17 received from hospital providers under Section 5A-4 for the
18 portion of State fiscal year 2012 beginning June 10, 2012
19 through June 30, 2012 and transferred into the Hospital
20 Provider Fund under Section 5A-6 to the designated funds
21 not exceeding the following amounts in that State fiscal
22 year:

23 Healthcare Provider Relief Fund \$2,870,000

24 Since the federal Centers for Medicare and Medicaid
25 Services approval of the assessment authorized under
26 subsection (b-5) of Section 5A-2, received from hospital

1 providers under Section 5A-4 and the payment methodologies
 2 to hospitals required under Section 5A-12.4 was not
 3 received by the Department until State fiscal year 2014 and
 4 since the Department made retroactive payments during
 5 State fiscal year 2014 related to the referenced period of
 6 June 2012, the transfer authority granted in this paragraph
 7 (7.12) is extended through the date that is 10 State
 8 business days after June 16, 2014 (the effective date of
 9 Public Act 98-651).

10 (7.13) In addition to any other transfers authorized
 11 under this Section, for State fiscal years 2017 and 2018,
 12 for making transfers to the Healthcare Provider Relief Fund
 13 of moneys collected from the ACA Assessment Adjustment
 14 authorized under subsections (a) and (b-5) of Section 5A-2
 15 and paid by hospital providers under Section 5A-4 into the
 16 Hospital Provider Fund under Section 5A-6 for each State
 17 fiscal year. Timing of transfers to the Healthcare Provider
 18 Relief Fund under this paragraph shall be at the discretion
 19 of the Department, but no less frequently than quarterly.

20 (7.14) For making transfers not exceeding the
 21 following amounts, related to State fiscal years 2019 and
 22 2020 ~~through 2024~~, to the following designated funds:

23	Health and Human Services Medicaid Trust	
24	Fund	\$20,000,000
25	Long-Term Care Provider Fund	\$30,000,000
26	<u>Healthcare</u> Health-Care Provider Relief Fund	

1 \$325,000,000.

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

6 (7.15) For making transfers not exceeding the
7 following amounts, related to State fiscal years 2021 and
8 2022, to the following designated funds:

9	<u>Health and Human Services Medicaid Trust</u>	
10	Fund	<u>\$20,000,000</u>
11	<u>Long-Term Care Provider Fund</u>	<u>\$30,000,000</u>
12	<u>Healthcare Provider Relief Fund</u>	<u>\$365,000,000</u>

13 (7.16) For making transfers not exceeding the
14 following amounts, related to July 1, 2022 to December 31,
15 2022, to the following designated funds:

16	<u>Health and Human Services Medicaid Trust</u>	
17	Fund	<u>\$10,000,000</u>
18	<u>Long-Term Care Provider Fund</u>	<u>\$15,000,000</u>
19	<u>Healthcare Provider Relief Fund</u>	<u>\$182,500,000</u>

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

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

26 Disbursements from the Fund, other than transfers

1 authorized under paragraphs (5) and (6) of this subsection,
2 shall be by warrants drawn by the State Comptroller upon
3 receipt of vouchers duly executed and certified by the Illinois
4 Department.

5 (c) The Fund shall consist of the following:

6 (1) All moneys collected or received by the Illinois
7 Department from the hospital provider assessment imposed
8 by this Article.

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

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

15 (3.5) As applicable, proceeds from surety bond
16 payments payable to the Department as referenced in
17 subsection (s) of Section 5A-12.2 of this Code.

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

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

22 (d) (Blank).

23 (Source: P.A. 99-78, eff. 7-20-15; 99-516, eff. 6-30-16;
24 99-933, eff. 1-27-17; 100-581, eff. 3-12-18; 100-863, eff.
25 8-14-19; revised 7-12-19.)

1 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

2 Sec. 5A-10. Applicability.

3 (a) The assessment imposed by subsection (a) of Section
4 5A-2 shall cease to be imposed and the Department's obligation
5 to make payments shall immediately cease, and any moneys
6 remaining in the Fund shall be refunded to hospital providers
7 in proportion to the amounts paid by them, if:

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

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

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

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

22 (C) any changes proposed in State plan amendment
23 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
24 08-07;

25 (D) in relation to any admissions on or after
26 January 1, 2011, a modification in the methodology for

1 calculating outlier payments to hospitals for
2 exceptionally costly stays, for hospitals reimbursed
3 under the diagnosis-related grouping methodology in
4 effect on July 1, 2011; provided that the Department
5 shall be limited to one such modification during the
6 36-month period after the effective date of this
7 amendatory Act of the 96th General Assembly;

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

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

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

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

25 (c) The assessments imposed by subsection (b-5) of Section
26 5A-2 shall not take effect or shall cease to be imposed, the

1 Department's obligation to make payments shall immediately
2 cease, and any moneys remaining in the Fund shall be refunded
3 to hospital providers in proportion to the amounts paid by
4 them, if the payments to hospitals required under Section
5 5A-12.4 or Section 5A-12.6 are not eligible for federal
6 matching funds under Title XIX of the Social Security Act.

7 (d) The assessments imposed by Section 5A-2 shall not take
8 effect or shall cease to be imposed, the Department's
9 obligation to make payments shall immediately cease, and any
10 moneys remaining in the Fund shall be refunded to hospital
11 providers in proportion to the amounts paid by them, if:

12 (1) for State fiscal years 2013 through 2018, and as
13 provided in Section 5A-16, the Department reduces any
14 payment rates to hospitals as in effect on May 1, 2012, or
15 alters any payment methodology as in effect on May 1, 2012,
16 that has the effect of reducing payment rates to hospitals,
17 except for any changes affecting hospitals authorized in
18 Public Act 97-689 and any changes authorized by Section
19 14-12 of this Code, and except for any changes authorized
20 under Section 5A-15, and except for any changes authorized
21 under Section 5-5b.1;

22 (2) for State fiscal years 2013 through 2018, and as
23 provided in Section 5A-16, the Department reduces any
24 supplemental payments made to hospitals below the amounts
25 paid for services provided in State fiscal year 2011 as
26 implemented by administrative rules adopted and in effect

1 on or prior to June 30, 2011, except for any changes
2 affecting hospitals authorized in Public Act 97-689 and any
3 changes authorized by Section 14-12 of this Code, and
4 except for any changes authorized under Section 5A-15, and
5 except for any changes authorized under Section 5-5b.1; or

6 (3) for State fiscal years 2015 through 2018, and as
7 provided in Section 5A-16, the Department reduces the
8 overall effective rate of reimbursement to hospitals below
9 the level authorized under Section 14-12 of this Code,
10 except for any changes under Section 14-12 or Section 5A-15
11 of this Code, and except for any changes authorized under
12 Section 5-5b.1.

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

20 (1) the payments to hospitals required under Section
21 5A-12.6 are not eligible for federal matching funds under
22 Title XIX of the Social Security Act; or

23 (2) the Department reduces the overall effective rate
24 of reimbursement to hospitals below the level authorized
25 under Section 14-12 of this Code, as in effect on December
26 31, 2017, except for any changes authorized under Sections

1 14-12 or Section 5A-15 of this Code, and except for any
2 changes authorized under changes to Sections 5A-12.2,
3 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by Public Act
4 100-581 ~~this amendatory Act of the 100th General Assembly.~~

5 (f) Beginning in State Fiscal Year 2021, the assessments
6 imposed under Section 5A-2 shall not take effect or shall cease
7 to be imposed, the Department's obligation to make payments
8 shall immediately cease, and any moneys remaining in the Fund
9 shall be refunded to hospital providers in proportion to the
10 amounts paid by them, if:

11 (1) the payments to hospitals required under Section
12 5A-12.7 are not eligible for federal matching funds under
13 Title XIX of the Social Security Act; or

14 (2) the Department reduces the overall effective rate
15 of reimbursement to hospitals below the level authorized
16 under Section 14-12, as in effect on December 31, 2019,
17 except for any changes authorized under Sections 14-12 or
18 5A-15, and except for any changes authorized under changes
19 to Sections 5A-12.7 and 14-12 made by this amendatory Act
20 of the 101st General Assembly.

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

22 (305 ILCS 5/5A-12.7 new)

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

25 (a) To preserve and improve access to hospital services,

1 for hospital services rendered on and after July 1, 2020, the
2 Department shall, except for hospitals described in subsection
3 (b) of Section 5A-3, make payments to hospitals or require
4 capitated managed care organizations to make payments as set
5 forth in this Section. Payments under this Section are not due
6 and payable, however, until: (i) the methodologies described in
7 this Section are approved by the federal government in an
8 appropriate State Plan amendment or directed payment preprint;
9 and (ii) the assessment imposed under this Article is
10 determined to be a permissible tax under Title XIX of the
11 Social Security Act. In determining the hospital access
12 payments authorized under subsection (g) of this Section, if a
13 hospital ceases to qualify for payments from the pool, the
14 payments for all hospitals continuing to qualify for payments
15 from such pool shall be uniformly adjusted to fully expend the
16 aggregate net amount of the pool, with such adjustment being
17 effective on the first day of the second month following the
18 date the hospital ceases to receive payments from such pool.

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

22 (c) Graduate medical education.

23 (1) The calculation of graduate medical education
24 payments shall be based on the hospital's Medicare cost
25 report ending in Calendar Year 2018, as reported in the
26 Healthcare Cost Report Information System file, release

1 date September 30, 2019. An Illinois hospital reporting
2 intern and resident cost on its Medicare cost report shall
3 be eligible for graduate medical education payments.

4 (2) Each hospital's annualized Medicaid Intern
5 Resident Cost is calculated using annualized intern and
6 resident total costs obtained from Worksheet B Part I,
7 Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93,
8 96-98, and 105-112 multiplied by the percentage that the
9 hospital's Medicaid days (Worksheet S3 Part I, Column 7,
10 Lines 2, 3, 4, 14, 16-18, and 32) comprise of the
11 hospital's total days (Worksheet S3 Part I, Column 8, Lines
12 14, 16-18, and 32).

13 (3) An annualized Medicaid indirect medical education
14 (IME) payment is calculated for each hospital using its IME
15 payments (Worksheet E Part A, Line 29, Column 1) multiplied
16 by the percentage that its Medicaid days (Worksheet S3 Part
17 I, Column 7, Lines 2, 3, 4, 14, 16-18, and 32) comprise of
18 its Medicare days (Worksheet S3 Part I, Column 6, Lines 2,
19 3, 4, 14, and 16-18).

20 (4) For each hospital, its annualized Medicaid Intern
21 Resident Cost and its annualized Medicaid IME payment are
22 summed, and, except as capped at 120% of the average cost
23 per intern and resident for all qualifying hospitals as
24 calculated under this paragraph, is multiplied by 22.6% to
25 determine the hospital's final graduate medical education
26 payment. Each hospital's average cost per intern and

1 resident shall be calculated by summing its total
2 annualized Medicaid Intern Resident Cost plus its
3 annualized Medicaid IME payment and dividing that amount by
4 the hospital's total Full Time Equivalent Residents and
5 Interns. If the hospital's average per intern and resident
6 cost is greater than 120% of the same calculation for all
7 qualifying hospitals, the hospital's per intern and
8 resident cost shall be capped at 120% of the average cost
9 for all qualifying hospitals.

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

20 (1) For critical access hospitals, \$385 per covered
21 inpatient day contained in paid fee-for-service claims and
22 \$530 per paid fee-for-service outpatient claim for dates of
23 service in Calendar Year 2019 in the Department's
24 Enterprise Data Warehouse as of May 11, 2020.

25 (2) For safety-net hospitals, \$960 per covered
26 inpatient day contained in paid fee-for-service claims and

1 \$625 per paid fee-for-service outpatient claim for dates of
2 service in Calendar Year 2019 in the Department's
3 Enterprise Data Warehouse as of May 11, 2020.

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

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

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

18 (6) For all general acute care hospitals and high
19 Medicaid hospitals as defined in subsection (f), \$350 per
20 covered inpatient day for dates of service in Calendar Year
21 2019 contained in paid fee-for-service claims and \$620 per
22 paid fee-for-service outpatient claim in the Department's
23 Enterprise Data Warehouse as of May 11, 2020.

24 (7) Alzheimer's treatment access payment. Each
25 Illinois academic medical center or teaching hospital, as
26 defined in Section 5-5e.2 of this Code, that is identified

1 as the primary hospital affiliate of one of the Regional
2 Alzheimer's Disease Assistance Centers, as designated by
3 the Alzheimer's Disease Assistance Act and identified in
4 the Department of Public Health's Alzheimer's Disease
5 State Plan dated December 2016, shall be paid an
6 Alzheimer's treatment access payment equal to the product
7 of the qualifying hospital's State Fiscal Year 2018 total
8 inpatient fee-for-service days multiplied by the
9 applicable Alzheimer's treatment rate of \$226.30 for
10 hospitals located in Cook County and \$116.21 for hospitals
11 located outside Cook County.

12 (e) The Department shall require managed care
13 organizations (MCOs) to make directed payments and
14 pass-through payments according to this Section. Each calendar
15 year, the Department shall require MCOs to pay the maximum
16 amount out of these funds as allowed as pass-through payments
17 under federal regulations. The Department shall require MCOs to
18 make such pass-through payments as specified in this Section.
19 The Department shall require the MCOs to pay the remaining
20 amounts as directed Payments as specified in this Section. The
21 Department shall issue payments to the Comptroller by the
22 seventh business day of each month for all MCOs that are
23 sufficient for MCOs to make the directed payments and
24 pass-through payments according to this Section. The
25 Department shall require the MCOs to make pass-through payments
26 and directed payments using electronic funds transfers (EFT),

1 if the hospital provides the information necessary to process
2 such EFTs, in accordance with directions provided monthly by
3 the Department, within 7 business days of the date the funds
4 are paid to the MCOs, as indicated by the "Paid Date" on the
5 website of the Office of the Comptroller if the funds are paid
6 by EFT and the MCOs have received directed payment
7 instructions. If funds are not paid through the Comptroller by
8 EFT, payment must be made within 7 business days of the date
9 actually received by the MCO. The MCO will be considered to
10 have paid the pass-through payments when the payment remittance
11 number is generated or the date the MCO sends the check to the
12 hospital, if EFT information is not supplied. If an MCO is late
13 in paying a pass-through payment or directed payment as
14 required under this Section (including any extensions granted
15 by the Department), it shall pay a penalty, unless waived by
16 the Department for reasonable cause, to the Department equal to
17 5% of the amount of the pass-through payment or directed
18 payment not paid on or before the due date plus 5% of the
19 portion thereof remaining unpaid on the last day of each 30-day
20 period thereafter. Payments to MCOs that would be paid
21 consistent with actuarial certification and enrollment in the
22 absence of the increased capitation payments under this Section
23 shall not be reduced as a consequence of payments made under
24 this subsection. The Department shall publish and maintain on
25 its website for a period of no less than 8 calendar quarters,
26 the quarterly calculation of directed payments and

1 pass-through payments owed to each hospital from each MCO. All
2 calculations and reports shall be posted no later than the
3 first day of the quarter for which the payments are to be
4 issued.

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

9 (A) Critical access hospitals.

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

13 (C) Long term acute care hospitals.

14 (D) Freestanding psychiatric hospitals.

15 (E) Freestanding rehabilitation hospitals.

16 (F) High Medicaid hospitals. As used in this Section,
17 "high Medicaid hospital" means a general acute care
18 hospital that is not a safety-net hospital or critical
19 access hospital and that has a Medicaid Inpatient
20 Utilization Rate above 30% or a hospital that had over
21 35,000 inpatient Medicaid days during the applicable
22 period. For the period July 1, 2020 through December 31,
23 2020, the applicable period for the Medicaid Inpatient
24 Utilization Rate (MIUR) is the rate year 2020 MIUR and for
25 the number of inpatient days it is State fiscal year 2018.
26 Beginning in calendar year 2021, the Department shall use

1 the most recently determined MIUR, as defined in subsection
2 (h) of Section 5-5.02, and for the inpatient day threshold,
3 the State fiscal year ending 18 months prior to the
4 beginning of the calendar year. For purposes of calculating
5 MIUR under this Section, children's hospitals and
6 affiliated general acute care hospitals shall be
7 considered a single hospital.

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

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

17 (g) Fixed pool directed payments. Beginning July 1, 2020,
18 the Department shall issue payments to MCOs which shall be used
19 to issue directed payments to qualified Illinois safety-net
20 hospitals and critical access hospitals on a monthly basis in
21 accordance with this subsection. Prior to the beginning of each
22 Payout Quarter beginning July 1, 2020, the Department shall use
23 encounter claims data from the Determination Quarter, accepted
24 by the Department's Medicaid Management Information System for
25 inpatient and outpatient services rendered by safety-net
26 hospitals and critical access hospitals to determine a

1 quarterly uniform per unit add-on for each hospital class.

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

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

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

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

25 (A) Each hospital in the class shall have a
26 quarterly outpatient directed payment calculated that

1 is equal to the product of the number of outpatient
2 encounter claims attributable to the hospital used in
3 the calculation of the quarterly uniform class per
4 claim add-on, multiplied by the calculated applicable
5 quarterly uniform class per claim add-on of the
6 hospital class.

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

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

14 (4) Definitions. As used in this subsection:

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

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

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

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

26 (B) \$4,294,374 for hospital outpatient services

1 for critical access hospitals.

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

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

6 (h) Fixed rate directed payments. Effective July 1, 2020,
7 the Department shall issue payments to MCOs which shall be used
8 to issue directed payments to Illinois hospitals not identified
9 in paragraph (g) on a monthly basis. Prior to the beginning of
10 each Payout Quarter beginning July 1, 2020, the Department
11 shall use encounter claims data from the Determination Quarter,
12 accepted by the Department's Medicaid Management Information
13 System for inpatient and outpatient services rendered by
14 hospitals in each hospital class identified in paragraph (f)
15 and not identified in paragraph (g). For the period July 1,
16 2020 through December 2020, the Department shall direct MCOs to
17 make payments as follows:

18 (1) For general acute care hospitals an amount equal to
19 \$1,750 multiplied by the hospital's category of service 20
20 case mix index for the determination quarter multiplied by
21 the hospital's total number of inpatient admissions for
22 category of service 20 for the determination quarter.

23 (2) For general acute care hospitals an amount equal to
24 \$160 multiplied by the hospital's category of service 21
25 case mix index for the determination quarter multiplied by
26 the hospital's total number of inpatient admissions for

1 category of service 21 for the determination quarter.

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

7 (4) For general acute care hospitals an amount equal to
8 \$375 multiplied by the hospital's category of service 24
9 case mix index for the determination quarter multiplied by
10 the hospital's total number of category of service 24 paid
11 EAPG (EAPGs) for the determination quarter.

12 (5) For general acute care hospitals an amount equal to
13 \$240 multiplied by the hospital's category of service 27
14 and 28 case mix index for the determination quarter
15 multiplied by the hospital's total number of category of
16 service 27 and 28 paid EAPGs for the determination quarter.

17 (6) For general acute care hospitals an amount equal to
18 \$290 multiplied by the hospital's category of service 29
19 case mix index for the determination quarter multiplied by
20 the hospital's total number of category of service 29 paid
21 EAPGs for the determination quarter.

22 (7) For high Medicaid hospitals an amount equal to
23 \$1,800 multiplied by the hospital's category of service 20
24 case mix index for the determination quarter multiplied by
25 the hospital's total number of inpatient admissions for
26 category of service 20 for the determination quarter.

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

6 (9) For high Medicaid hospitals an amount equal to \$80
7 multiplied by the hospital's category of service 22 case
8 mix index for the determination quarter multiplied by the
9 hospital's total number of inpatient admissions for
10 category of service 22 for the determination quarter.

11 (10) For high Medicaid hospitals an amount equal to
12 \$400 multiplied by the hospital's category of service 24
13 case mix index for the determination quarter multiplied by
14 the hospital's total number of category of service 24 paid
15 EAPG outpatient claims for the determination quarter.

16 (11) For high Medicaid hospitals an amount equal to
17 \$240 multiplied by the hospital's category of service 27
18 and 28 case mix index for the determination quarter
19 multiplied by the hospital's total number of category of
20 service 27 and 28 paid EAPGs for the determination quarter.

21 (12) For high Medicaid hospitals an amount equal to
22 \$290 multiplied by the hospital's category of service 29
23 case mix index for the determination quarter multiplied by
24 the hospital's total number of category of service 29 paid
25 EAPGs for the determination quarter.

26 (13) For long term acute care hospitals the amount of

1 \$495 multiplied by the hospital's total number of inpatient
2 days for the determination quarter.

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

6 (15) For psychiatric hospitals the amount of \$250
7 multiplied by the hospital's total number of outpatient
8 claims for category of service 27 and 28 for the
9 determination quarter.

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

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

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

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

24 Notwithstanding any other provision of this subsection, if
25 the Department determines that the actual total hospital
26 utilization data that is used to calculate the fixed rate

1 directed payments is substantially different than anticipated
2 when the rates in this subsection were initially determined
3 (for unforeseeable circumstances such as the COVID-19
4 pandemic), the Department may adjust the rates specified in
5 this subsection so that the total directed payments approximate
6 the total spending amount anticipated when the rates were
7 initially established.

8 Definitions. As used in this subsection:

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

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

14 (C) "Case mix index" means a hospital specific
15 calculation. For inpatient claims the case mix index is
16 calculated each quarter by summing the relative weight
17 of all inpatient Diagnosis-Related Group (DRG) claims
18 for a category of service in the applicable
19 Determination Quarter and dividing the sum by the
20 number of sum total of all inpatient DRG admissions for
21 the category of service for the associated claims. The
22 case mix index for outpatient claims is calculated each
23 quarter by summing the relative weight of all paid
24 EAPGs in the applicable Determination Quarter and
25 dividing the sum by the sum total of paid EAPGs for the
26 associated claims.

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

8 (j) Pass-through payments.

9 (1) For the period July 1, 2020 through December 31,
10 2020, the Department shall assign quarterly pass-through
11 payments to each class of hospitals equal to one-fourth of
12 the following annual allocations:

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

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

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

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

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

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

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

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

1 received through payments referenced in subsection (b).

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

7 (k) At least 30 days prior to each calendar year, the
8 Department shall notify each hospital of changes to the payment
9 methodologies in this Section, including, but not limited to,
10 changes in the fixed rate directed payment rates, the aggregate
11 pass-through payment amount for all hospitals, and the
12 hospital's pass-through payment amount for the upcoming
13 calendar year.

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

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

1 (305 ILCS 5/5A-12.8 new)

2 Sec. 5A-12.8. Report to the General Assembly. In order to
3 facilitate transparency, accountability, and future policy
4 development by the General Assembly, the Department shall
5 provide the reports and information specified in this Section.
6 By February 1, 2022, the Department shall provide a report to
7 the General Assembly that includes, but is not limited to, the
8 following:

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

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

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

19 (B) analysis of charity care by hospital;

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

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

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

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

6 (305 ILCS 5/5A-13)

7 Sec. 5A-13. Emergency rulemaking.

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

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

25 (c) The Department of Healthcare and Family Services may

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

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

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

10 (e) The Department of Healthcare and Family Services may
11 adopt rules necessary to implement the changes made to Articles
12 5, 5A, 12, and 14 of this Code by this amendatory Act of the
13 101st General Assembly through the use of emergency rulemaking
14 in accordance with Section 5-45.1 of the Illinois
15 Administrative Procedure Act. The 24-month limitation on the
16 adoption of emergency rules does not apply to rules adopted
17 under this Section. The General Assembly finds that the
18 adoption of rules to implement the changes made to Articles 5,
19 5A, 12, and 14 of this Code by this amendatory Act of the 101st
20 General Assembly is deemed an emergency and necessary for the
21 public interest, safety, and welfare.

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

23 (305 ILCS 5/5A-14)

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

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

1 ~~2020.~~

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

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

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

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

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

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

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

10 (305 ILCS 5/5A-17 new)

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

12 (a) As a condition of receiving payments pursuant to
13 subsections (d) and (k) of Section 5A-12.7 for State Fiscal
14 Year 2021, a for-profit general acute care hospital that ceases
15 to provide hospital services before July 1, 2021 and within 12
16 months of a change in the hospital's ownership status from
17 not-for-profit to investor owned, shall be obligated to pay to
18 the Department an amount equal to the payments received
19 pursuant to subsections (d) and (k) of Section 5A-12.7 since
20 the change in ownership status to the cessation of hospital
21 services. The obligated amount shall be due immediately and
22 must be paid to the Department within 10 days of ceasing to
23 provide services or pursuant to a payment plan approved by the
24 Department unless the hospital requests a hearing under
25 paragraph (d) of this Section. The obligation under this

1 Section shall not apply to a hospital that ceases to provide
2 services under circumstances that include: implementation of a
3 transformation project approved by the Department under
4 subsection (d-5) of Section 14-12; emergencies as declared by
5 federal, State, or local government; actions approved or
6 required by federal, State, or local government; actions taken
7 in compliance with the Illinois Health Facilities Planning Act;
8 or other circumstances beyond the control of the hospital
9 provider or for the benefit of the community previously served
10 by the hospital, as determined on a case-by-case basis by the
11 Department.

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

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

26 (2) No proceedings for collection, refund, credit, or

1 other adjustment of an amount payable under this Section
2 shall be issued more than 3 years after the due date of the
3 obligation, except in the case of an extended period agreed
4 to in writing by the Illinois Department and the hospital
5 provider before the expiration of this limitation period.

6 (3) Any unpaid obligation under this Section shall
7 become a lien upon the assets of the hospital. If any
8 hospital provider sells or transfers the major part of any
9 one or more of (i) the real property and improvements, (ii)
10 the machinery and equipment, or (iii) the furniture or
11 fixtures of any hospital that is subject to the provisions
12 of this Section, the seller or transferor shall pay the
13 Illinois Department the amount of any obligation due from
14 it under this Section up to the date of the sale or
15 transfer. If the seller or transferor fails to pay any
16 amount due under this Section, the purchaser or transferee
17 of such asset shall be liable for the amount of the
18 obligation up to the amount of the reasonable value of the
19 property acquired by the purchaser or transferee. The
20 purchaser or transferee shall continue to be liable until
21 the purchaser or transferee pays the full amount of the
22 obligation up to the amount of the reasonable value of the
23 property acquired by the purchaser or transferee or until
24 the purchaser or transferee receives from the Illinois
25 Department a certificate showing that such assessment,
26 penalty, and interest have been paid or a certificate from

1 the Illinois Department showing that no amount is due from
2 the seller or transferor under this Section.

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

8 (305 ILCS 5/12-4.105)

9 Sec. 12-4.105. Human poison control center; payment
10 program. Subject to funding availability resulting from
11 transfers made from the Hospital Provider Fund to the
12 Healthcare Provider Relief Fund as authorized under this Code,
13 for State fiscal year 2017 and State fiscal year 2018, and for
14 each State fiscal year thereafter in which the assessment under
15 Section 5A-2 is imposed, the Department of Healthcare and
16 Family Services shall pay to the human poison control center
17 designated under the Poison Control System Act an amount of not
18 less than \$3,000,000 for each of ~~those~~ State fiscal years 2017
19 through 2020, and for State fiscal year 2021 and 2022 an amount
20 of not less than \$3,750,000 and for the period July 1, 2022
21 through December 31, 2022 an amount of not less than
22 \$1,875,000, if ~~that~~ the human poison control center is in
23 operation.

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

1 (305 ILCS 5/14-12)

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

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

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

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

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

26 (4) The Department shall develop add-on payments to

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

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

14 (6) Beginning July 1, 2014 and ending on June 30, 2024,
15 in addition to the statewide-standardized amount, the
16 Department shall develop an adjustor to adjust the rate of
17 reimbursement for safety-net hospitals defined in Section
18 5-5e.1 of this Code excluding pediatric hospitals.

19 (7) Beginning July 1, 2014 ~~and ending on June 30, 2020,~~
20 ~~or upon implementation of inpatient psychiatric rate~~
21 ~~increases as described in subsection (n) of Section~~
22 ~~5A-12.6~~, in addition to the statewide-standardized amount,
23 the Department shall develop an adjustor to adjust the rate
24 of reimbursement for Illinois freestanding inpatient
25 psychiatric hospitals that are not designated as
26 children's hospitals by the Department but are primarily

1 treating patients under the age of 21.

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

23 (8) Beginning July 1, 2018, in addition to the
24 statewide-standardized amount, the Department shall adjust
25 the rate of reimbursement for hospitals designated by the
26 Department of Public Health as a Perinatal Level II or II+

1 center by applying the same adjustor that is applied to
2 Perinatal and Obstetrical care cases for Perinatal Level
3 III centers, as of December 31, 2017.

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

10 (10) Beginning July 1, 2018, the
11 statewide-standardized amount for inpatient general acute
12 care services shall be uniformly increased so that base
13 claims projected reimbursement is increased by an amount
14 equal to the funds allocated in paragraph (1) of subsection
15 (b) of Section 5A-12.6, less the amount allocated under
16 paragraphs (8) and (9) of this subsection and paragraphs
17 (3) and (4) of subsection (b) multiplied by 40%. ~~Beginning~~
18 ~~July 1, 2020, the statewide standardized amount for~~
19 ~~inpatient general acute care services shall be uniformly~~
20 ~~increased so that base claims projected reimbursement is~~
21 ~~increased by an amount equal to the funds allocated in~~
22 ~~paragraph (2) of subsection (b) of Section 5A-12.6, less~~
23 ~~the amount allocated under paragraphs (8) and (9) of this~~
24 ~~subsection and paragraphs (3) and (4) of subsection (b)~~
25 ~~multiplied by 40%. Beginning July 1, 2022, the~~
26 ~~statewide standardized amount for inpatient general acute~~

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

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

18 ~~Beginning July 1, 2020, the reimbursement for~~
19 ~~inpatient rehabilitation services shall be uniformly~~
20 ~~increased so that the \$96 per day add-on is increased by an~~
21 ~~amount equal to the funds allocated in paragraph (2) of~~
22 ~~subsection (b) of Section 5A-12.6, less the amount~~
23 ~~allocated under paragraphs (8) and (9) of this subsection~~
24 ~~and paragraphs (3) and (4) of subsection (b) multiplied by~~
25 ~~0.9%.~~

26 ~~Beginning July 1, 2022, the reimbursement for~~

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

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

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

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

26 (2) The Department shall establish service specific

1 statewide-standardized amounts to be used in the
2 reimbursement system.

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

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

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

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

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

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

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

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

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

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

19 (1) Any recalculation to the
20 statewide-standardized amounts for outpatient services
21 provided by hospitals that are not Critical Access
22 Hospitals shall be the amount necessary to achieve the
23 increase in the statewide-standardized amounts for
24 outpatient services increased by a uniform percentage,
25 so that base claims projected reimbursement is
26 increased by an amount equal to no less than the funds

1 allocated in paragraph (1) of subsection (b) of Section
2 5A-12.6, less the amount allocated under paragraphs
3 (8) and (9) of subsection (a) and paragraphs (3) and
4 (4) of this subsection, for all hospitals that are not
5 Critical Access Hospitals, multiplied by 46%.

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

20 (8) The Department shall ensure that all necessary
21 adjustments to the managed care organization capitation
22 base rates necessitated by the adjustments under
23 subparagraph (6) or (7) of this subsection are completed
24 and applied retroactively in accordance with Section
25 5-30.8 of this Code within 90 days of March 8, 2019 (the
26 effective date of Public Act 100-1181) ~~this amendatory Act~~

1 ~~of the 100th General Assembly.~~

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

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

24 (1) Phase 1. In State fiscal years 2019 through 2020,
25 the Department shall allocate funds from the transitional
26 access hospital pool to create a hospital transformation

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

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

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

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

1 payment authorized under subsection (f).

2 (2) Phase 2.

3 (A) The funding amount from phase one shall be
4 incorporated into directed payment and pass-through
5 payment methodologies described in Section 5A-12.7.

6 ~~During State fiscal years 2021 and 2022, the Department~~
7 ~~shall allocate funds from the transitional access~~
8 ~~hospital pool to create a hospital transformation pool~~
9 ~~annually and make hospital transformation payments to~~
10 ~~hospitals participating in the transformation program.~~

11 ~~Any hospital may seek transformation funding in Phase~~
12 ~~2. Any hospital that seeks transformation funding in~~
13 ~~Phase 2 to update or repurpose the hospital's physical~~

14 ~~structure to transition to a new delivery model, must~~
15 ~~submit to the Department in writing a transformation~~
16 ~~plan, based on the Department's guidelines, that~~

17 ~~describes the desired delivery model with projections~~
18 ~~of patient volumes by service lines and projected~~
19 ~~revenues, expenses, and net income that correspond to~~

20 ~~the new delivery model. In Phase 2, subject to the~~
21 ~~approval of rules, the Department may use the hospital~~

22 ~~transformation pool to increase base rates, develop~~
23 ~~new adjusters, adjust current adjusters, or develop~~

24 ~~new access payments in order to support and incentivize~~
25 ~~hospitals to pursue such transformation. In developing~~

26 ~~such methodologies, the Department shall ensure that~~

1 ~~the entire hospital transformation pool continues to~~
2 ~~be expended to ensure access to hospital services or to~~
3 ~~support organizations that had received hospital~~
4 ~~transformation payments under this Section.~~

5 (B) Whereas there are communities in Illinois that
6 suffer from significant health care disparities
7 aggravated by social determinants of health and a lack
8 of sufficiently allocated healthcare resources,
9 particularly community-based services and preventive
10 care, there is established a new hospital and health
11 care transformation program, which shall be supported
12 by a transformation funding pool. An application for
13 funding from the hospital and health care
14 transformation program may incorporate the campus of a
15 hospital closed after January 1, 2018 or a hospital
16 that has provided notice of its intent to close
17 pursuant to Section 8.7 of the Illinois Health
18 Facilities Planning Act. During State Fiscal Years
19 2021 through 2023, the hospital and health care
20 transformation program shall be supported by an annual
21 transformation funding pool of at least \$150,000,000
22 to be allocated during the specified fiscal years for
23 the purpose of facilitating hospital and health care
24 transformation. The Department shall not allocate
25 funds associated with the hospital and health care
26 transformation pool as established in this

1 subparagraph until the General Assembly has
2 established in law or resolution, further criteria for
3 dispersal or allocation of those funds after the
4 effective date of this amendatory Act of 101st General
5 Assembly.

6 ~~(A) Any hospital participating in the hospital~~
7 ~~transformation program shall provide an opportunity~~
8 ~~for public input by local community groups, hospital~~
9 ~~workers, and healthcare professionals and assist in~~
10 ~~facilitating discussions about any transformations or~~
11 ~~changes to the hospital.~~

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

23 (D) ~~(C)~~ As provided in subsection (a-20) of Section
24 32.5 of the Emergency Medical Services (EMS) Systems
25 Act, a hospital that received hospital transformation
26 payments under this Section may convert to a

1 freestanding emergency center. To be eligible for such
2 a conversion, the hospital must submit to the
3 Department of Public Health approval ~~certification~~
4 from the Department, ~~approved by the Hospital~~
5 ~~Transformation Review Committee,~~ that the project is a
6 part of the hospital's transformation.

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

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

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

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

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

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

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

21 (i) Except for subsections (g) and (h) of this Section, the
22 Department shall, pursuant to subsection (c) of Section 5-40 of
23 the Illinois Administrative Procedure Act, provide for
24 presentation at the June 2014 hearing of the Joint Committee on
25 Administrative Rules (JCAR) additional written notice to JCAR
26 of the following rules in order to commence the second notice

1 period for the following rules: rules published in the Illinois
2 Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559
3 (Medical Payment), 4628 (Specialized Health Care Delivery
4 Systems), 4640 (Hospital Services), 4932 (Diagnostic Related
5 Grouping (DRG) Prospective Payment System (PPS)), and 4977
6 (Hospital Reimbursement Changes), and published in the
7 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499
8 (Specialized Health Care Delivery Systems) and 6505 (Hospital
9 Services).

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

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

22 (Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19;
23 101-81, eff. 7-12-19; revised 7-29-19.)

24 Section 97. Severability. If any provision of this Act or
25 application thereof to any person or circumstance is held

1 invalid, such invalidity does not affect other provisions or
2 applications of this Act which can be given effect without the
3 invalid application or provision, and to this end the
4 provisions of this Act are declared to be severable.

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