SB1763

LRB103 27744 KTG 54122 b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB1763

Introduced 2/9/2023, by Sen. Ann Gillespie

SYNOPSIS AS INTRODUCED:

See Index

Amends the Hospital Services Trust Fund Article of the Illinois Public Aid Code. Increases by 20% hospital reimbursement rates for dates of service on and after January 1, 2024, for specified services, including, but not limited to: inpatient general acute care services; inpatient psychiatric services for safety-net hospitals; general acute care hospitals that are not safety-net hospitals; and outpatient general acute care services. Provides that the rates for the listed services shall be increased, beginning on January 1, 2025 and each January 1 thereafter, based on the annual increase in the national hospital market basket price proxies (DRI) hospital cost index from the midpoint of the calendar year 2 years prior to the current year, to the midpoint of the preceding calendar year. Provides that in no instance shall the adjustment result in a reduction to the rates in place at the time of the required adjustment. Provides that if the federal Centers for Medicare and Medicaid Services finds that the increases required under the amendatory Act would result in rates of reimbursement which exceed the federal maximum limits applicable to hospital payments, then the payments and assessment tax imposed on hospital providers shall be reduced as provided in the Hospital Provider Funding Article. Requires the Department of Healthcare and Family Services to promptly take all actions necessary to ensure the changes authorized in the amendatory Act are in effect for dates of service on and after January 1, 2024. Requires the Department to ensure that all necessary adjustments to the managed care organization capitation base rates necessitated by the adjustments in the amendatory Act are completed, published, and applied 90 days prior to the implementation date of the changes required under the amendatory Act. Provides that, by October 1, 2023, the Department shall by rule implement a methodology effective for dates of service beginning on and after January 1, 2024 to reimburse hospitals for extended stays in a hospital emergency department. Amends the Illinois Administrative Procedure Act. Grants the Department emergency rulemaking authority. Effective immediately.

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A BILL FOR

AN ACT concerning public aid.

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

Section 1. The Illinois Administrative Procedure Act is amended by adding Section 5-45.35 as follows:

(5 ILCS 100/5-45.35 new)

Sec. 5-45.35. Emergency rulemaking; Medicaid reimbursement rates for hospital inpatient and outpatient services. To provide for the expeditious and timely implementation of the changes made by this amendatory Act of the 103rd General Assembly to Sections 5-5.05, 14-12, 14-12.5, and 14-13 of the Illinois Public Aid Code, emergency rules implementing the changes made by this amendatory Act of the 103rd General Assembly to Sections 5-5.05, 14-12, 14-12.5, and 14-13 of the Illinois Public Aid Code may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed one year after the effective date of this amendatory Act of the 103rd General Assembly.

Section 5. The Illinois Public Aid Code is amended by

1 changing Sections 5-5.05, 14-12, and 14-13 and by adding
2 Section 14-12.5 as follows:

3 (305 ILCS 5/5-5.05)
4 Sec. 5-5.05. Hospitals; psychiatric services.
5 (a) On and after July 1, 2008, the inpatient, per diem rate
6 to be paid to a hospital for inpatient psychiatric services
7 shall be <u>not less than</u> $363.77.
8 (b) For purposes of this Section, "hospital" means the
9 following:
10 (1) Advocate Christ Hospital, Oak Lawn, Illinois.
11 (2) Barnes-Jewish Hospital, St. Louis, Missouri.
12 (3) BroMenn Healthcare, Bloomington, Illinois.
13 (4) Jackson Park Hospital, Chicago, Illinois.
14 (5) Katherine Shaw Bethea Hospital, Dixon, Illinois.
15 (6) Lawrence County Memorial Hospital, Lawrenceville,
16 Illinois.
17 (7) Advocate Lutheran General Hospital, Park Ridge,
18 Illinois.
19 (8) Mercy Hospital and Medical Center, Chicago,
20 Illinois.
21 (9) Methodist Medical Center of Illinois, Peoria,
22 Illinois.
23 (10) Provena United Samaritans Medical Center,
24 Danville, Illinois.
25 (11) Rockford Memorial Hospital, Rockford, Illinois.

1 (12) Sarah Bush Lincoln Health Center, Mattoon,
2 Illinois.
3 (13) Provena Covenant Medical Center, Urbana,
4 Illinois.
5 (14) Rush-Presbyterian-St. Luke's Medical Center,
6 Chicago, Illinois.
7 (15) Mt. Sinai Hospital, Chicago, Illinois.
8 (16) Gateway Regional Medical Center, Granite City,
9 Illinois.
10 (17) St. Mary of Nazareth Hospital, Chicago, Illinois.
11 (18) Provena St. Mary's Hospital, Kankakee, Illinois.
12 (19) St. Mary's Hospital, Decatur, Illinois.
13 (20) Memorial Hospital, Belleville, Illinois.
14 (21) Swedish Covenant Hospital, Chicago, Illinois.
15 (22) Trinity Medical Center, Rock Island, Illinois.
16 (23) St. Elizabeth Hospital, Chicago, Illinois.
17 (24) Richland Memorial Hospital, Olney, Illinois.
18 (25) St. Elizabeth's Hospital, Belleville, Illinois.
19 (26) Samaritan Health System, Clinton, Iowa.
20 (27) St. John's Hospital, Springfield, Illinois.
21 (28) St. Mary's Hospital, Centralia, Illinois.
22 (29) Loretto Hospital, Chicago, Illinois.
23 (30) Kenneth Hall Regional Hospital, East St. Louis,
24 Illinois.
25 (31) Hinsdale Hospital, Hinsdale, Illinois.
26 (32) Pekin Hospital, Pekin, Illinois.

1 (33) University of Chicago Medical Center, Chicago,
2 Illinois.
3 (34) St. Anthony's Health Center, Alton, Illinois.
4 (35) OSF St. Francis Medical Center, Peoria, Illinois.
5 (36) Memorial Medical Center, Springfield, Illinois.
6 (37) A hospital with a distinct part unit for
7 psychiatric services that begins operating on or after
8 July 1, 2008.
9 For purposes of this Section, "inpatient psychiatric
10 services" means those services provided to patients who are in
11 need of short-term acute inpatient hospitalization for active
12 treatment of an emotional or mental disorder.
13 (b-5) Notwithstanding any other provision of this Section,
14 ~~and subject to appropriation,~~ the inpatient, per diem rate to
15 be paid to all safety-net hospitals for inpatient psychiatric
16 services on and after January 1, 2021 shall be at least $630,
17 subject to the provisions of Section 14-12.5.
18 (b-10) Notwithstanding any other provision of this
19 Section, effective with dates of service on and after January
20 1, 2022, any general acute care hospital with more than 9,500
21 inpatient psychiatric Medicaid days in any calendar year shall
22 be paid the inpatient per diem rate of no less than $630,
23 subject to the provisions of Section 14-12.5.
24 (c) No rules shall be promulgated to implement this
25 Section. For purposes of this Section, "rules" is given the
26 meaning contained in Section 1-70 of the Illinois

1 Administrative Procedure Act.

2 (d) (Blank). ~~This Section shall not be in effect during~~
3 ~~any period of time that the State has in place a fully~~
4 ~~operational hospital assessment plan that has been approved by~~
5 ~~the Centers for Medicare and Medicaid Services of the U.S.~~
6 ~~Department of Health and Human Services.~~

7 (e) On and after July 1, 2012, the Department shall reduce
8 any rate of reimbursement for services or other payments or
9 alter any methodologies authorized by this Code to reduce any
10 rate of reimbursement for services or other payments in
11 accordance with Section 5-5e.

12 (Source: P.A. 102-4, eff. 4-27-21; 102-674, eff. 11-30-21.)

13 (305 ILCS 5/14-12)

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

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

22 (1) The Department shall establish Medicaid weighting
23 factors to be used in the reimbursement system established
24 under this subsection. Initial weighting factors shall be
25 the weighting factors as published by 3M Health

1 Information System, associated with Version 30.0 adjusted
2 for the Illinois experience.
3 (2) The Department shall establish a
4 statewide-standardized amount to be used in the inpatient
5 reimbursement system. The Department shall publish these
6 amounts on its website no later than 10 calendar days
7 prior to their effective date.
8 (3) In addition to the statewide-standardized amount,
9 the Department shall develop adjusters to adjust the rate
10 of reimbursement for critical Medicaid providers or
11 services for trauma, transplantation services, perinatal
12 care, and Graduate Medical Education (GME).
13 (4) The Department shall develop add-on payments to
14 account for exceptionally costly inpatient stays,
15 consistent with Medicare outlier principles. Outlier fixed
16 loss thresholds may be updated to control for excessive
17 growth in outlier payments no more frequently than on an
18 annual basis, but at least once every 4 years. Upon
19 updating the fixed loss thresholds, the Department shall
20 be required to update base rates within 12 months.
21 (5) The Department shall define those hospitals or
22 distinct parts of hospitals that shall be exempt from the
23 APR-DRG reimbursement system established under this
24 Section. The Department shall publish these hospitals'
25 inpatient rates on its website no later than 10 calendar
26 days prior to their effective date.

(6) Beginning July 1, 2014 ~~and ending on June 30, 2024~~, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals, subject to the provisions of Section 14-12.5.

(7) Beginning July 1, 2014, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(7.5) (Blank).

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

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

842, 843, and 844.

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

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

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

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

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

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

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

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals. Beginning July 1, 2018, the outpatient high volume adjustor shall be increased to increase annual expenditures associated with this adjustor by $79,200,000, based on the State Fiscal Year 2015 base

1 year data and this adjustor shall apply to public
2 hospitals, except for large public hospitals, as defined
3 under 89 Ill. Adm. Code 148.25(a).
4 (4) Beginning July 1, 2018, in addition to the
5 statewide standardized amounts, the Department shall make
6 an add-on payment for outpatient expensive devices and
7 drugs. This add-on payment shall at least apply to claim
8 lines that: (i) are assigned with one of the following
9 EAPGs: 490, 1001 to 1020, and coded with one of the
10 following revenue codes: 0274 to 0276, 0278; or (ii) are
11 assigned with one of the following EAPGs: 430 to 441, 443,
12 444, 460 to 465, 495, 496, 1090. The add-on payment shall
13 be calculated as follows: the claim line's covered charges
14 multiplied by the hospital's total acute cost to charge
15 ratio, less the claim line's EAPG payment plus $1,000,
16 multiplied by 0.8.
17 (5) Beginning July 1, 2018, the statewide-standardized
18 amounts for outpatient services shall be increased by a
19 uniform percentage so that base claims projected
20 reimbursement is increased by an amount equal to no less
21 than the funds allocated in paragraph (1) of subsection
22 (b) of Section 5A-12.6, less the amount allocated under
23 paragraphs (8) and (9) of subsection (a) and paragraphs
24 (3) and (4) of this subsection multiplied by 46%.
25 (6) Effective for dates of service on or after July 1,
26 2018, the Department shall establish adjustments to the

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

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

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

1 allocated in paragraph (1) of subsection (b) of
2 Section 5A-12.6, less the amount allocated under
3 paragraphs (8) and (9) of subsection (a) and
4 paragraphs (3) and (4) of this subsection, for all
5 hospitals that are not Critical Access Hospitals,
6 multiplied by 46%.
7 (2) It is the intent of the General Assembly that
8 the recalculations required under this paragraph (7)
9 by Public Act 100-1181 shall be applied prospectively
10 to claims for dates of service provided on or after
11 March 8, 2019 (the effective date of Public Act
12 100-1181) and that no recoupment or repayment by the
13 Department or an MCO of payments attributable to
14 recalculation under this paragraph (7), issued to the
15 hospital for dates of service on or after July 1, 2018
16 and before March 8, 2019 (the effective date of Public
17 Act 100-1181), shall be permitted.
18 (8) The Department shall ensure that all necessary
19 adjustments to the managed care organization capitation
20 base rates necessitated by the adjustments under
21 subparagraph (6) or (7) of this subsection are completed
22 and applied retroactively in accordance with Section
23 5-30.8 of this Code within 90 days of March 8, 2019 (the
24 effective date of Public Act 100-1181).
25 (9) Within 60 days after federal approval of the
26 change made to the assessment in Section 5A-2 by Public

Act 101-650 ~~this amendatory Act of the 101st General Assembly~~, the Department shall incorporate into the EAPG system for outpatient services those services performed by hospitals currently billed through the Non-Institutional Provider billing system.

(b-5) Notwithstanding any other provision of this Section, beginning with dates of service on and after January 1, 2023, any general acute care hospital with more than 500 outpatient psychiatric Medicaid services to persons under 19 years of age in any calendar year shall be paid the outpatient add-on payment of no less than $113.

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

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the

1 Department. To help provide an orderly and predictable
2 transition to the new reimbursement systems and to preserve
3 and enhance access to the hospital services during this
4 transition, the Department shall allocate a transitional
5 hospital access pool of at least $290,000,000 annually so that
6 transitional hospital access payments are made to hospitals.
7 (1) After the transition period, the Department may
8 begin incorporating the transitional hospital access pool
9 into the base rate structure; however, the transitional
10 hospital access payments in effect on June 30, 2018 shall
11 continue to be paid, if continued under Section 5A-16.
12 (2) After the transition period, if the Department
13 reduces payments from the transitional hospital access
14 pool, it shall increase base rates, develop new adjustors,
15 adjust current adjustors, develop new hospital access
16 payments based on updated information, or any combination
17 thereof by an amount equal to the decreases proposed in
18 the transitional hospital access pool payments, ensuring
19 that the entire transitional hospital access pool amount
20 shall continue to be used for hospital payments.
21 (d-5) Hospital and health care transformation program. The
22 Department shall develop a hospital and health care
23 transformation program to provide financial assistance to
24 hospitals in transforming their services and care models to
25 better align with the needs of the communities they serve. The
26 payments authorized in this Section shall be subject to

1 approval by the federal government.
2 (1) Phase 1. In State fiscal years 2019 through 2020,
3 the Department shall allocate funds from the transitional
4 access hospital pool to create a hospital transformation
5 pool of at least $262,906,870 annually and make hospital
6 transformation payments to hospitals. Subject to Section
7 5A-16, in State fiscal years 2019 and 2020, an Illinois
8 hospital that received either a transitional hospital
9 access payment under subsection (d) or a supplemental
10 payment under subsection (f) of this Section in State
11 fiscal year 2018, shall receive a hospital transformation
12 payment as follows:
13 (A) If the hospital's Rate Year 2017 Medicaid
14 inpatient utilization rate is equal to or greater than
15 45%, the hospital transformation payment shall be
16 equal to 100% of the sum of its transitional hospital
17 access payment authorized under subsection (d) and any
18 supplemental payment authorized under subsection (f).
19 (B) If the hospital's Rate Year 2017 Medicaid
20 inpatient utilization rate is equal to or greater than
21 25% but less than 45%, the hospital transformation
22 payment shall be equal to 75% of the sum of its
23 transitional hospital access payment authorized under
24 subsection (d) and any supplemental payment authorized
25 under subsection (f).
26 (C) If the hospital's Rate Year 2017 Medicaid

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

Assembly that partnerships recognize and address the disparities revealed by the COVID-19 pandemic, as well as the need for post-COVID care. During State fiscal years 2021 through 2027, the hospital and health care transformation program shall be supported by an annual transformation funding pool of up to $150,000,000, pending federal matching funds, to be allocated during the specified fiscal years for the purpose of facilitating hospital and health care transformation. No disbursement of moneys for transformation projects from the transformation funding pool described under this Section shall be considered an award, a grant, or an expenditure of grant funds. Funding agreements made in accordance with the transformation program shall be considered purchases of care under the Illinois Procurement Code, and funds shall be expended by the Department in a manner that maximizes federal funding to expend the entire allocated amount.

The Department shall convene, within 30 days after March 12, 2021 (the effective date of Public Act 101-655) ~~this amendatory Act of the 101st General Assembly~~, a workgroup that includes subject matter experts on healthcare disparities and stakeholders from distressed communities, which could be a subcommittee of the Medicaid Advisory Committee, to review and provide recommendations on how Department

1 policy, including health care transformation, can
2 improve health disparities and the impact on
3 communities disproportionately affected by COVID-19.
4 The workgroup shall consider and make recommendations
5 on the following issues: a community safety-net
6 designation of certain hospitals, racial equity, and a
7 regional partnership to bring additional specialty
8 services to communities.
9 (C) As provided in paragraph (9) of Section 3 of
10 the Illinois Health Facilities Planning Act, any
11 hospital participating in the transformation program
12 may be excluded from the requirements of the Illinois
13 Health Facilities Planning Act for those projects
14 related to the hospital's transformation. To be
15 eligible, the hospital must submit to the Health
16 Facilities and Services Review Board approval from the
17 Department that the project is a part of the
18 hospital's transformation.
19 (D) As provided in subsection (a-20) of Section
20 32.5 of the Emergency Medical Services (EMS) Systems
21 Act, a hospital that received hospital transformation
22 payments under this Section may convert to a
23 freestanding emergency center. To be eligible for such
24 a conversion, the hospital must submit to the
25 Department of Public Health approval from the
26 Department that the project is a part of the

1 hospital's transformation.
2 (E) Criteria for proposals. To be eligible for
3 funding under this Section, a transformation proposal
4 shall meet all of the following criteria:
5 (i) the proposal shall be designed based on
6 community needs assessment completed by either a
7 University partner or other qualified entity with
8 significant community input;
9 (ii) the proposal shall be a collaboration
10 among providers across the care and community
11 spectrum, including preventative care, primary
12 care specialty care, hospital services, mental
13 health and substance abuse services, as well as
14 community-based entities that address the social
15 determinants of health;
16 (iii) the proposal shall be specifically
17 designed to improve healthcare outcomes and reduce
18 healthcare disparities, and improve the
19 coordination, effectiveness, and efficiency of
20 care delivery;
21 (iv) the proposal shall have specific
22 measurable metrics related to disparities that
23 will be tracked by the Department and made public
24 by the Department;
25 (v) the proposal shall include a commitment to
26 include Business Enterprise Program certified

vendors or other entities controlled and managed by minorities or women; and

(vi) the proposal shall specifically increase access to primary, preventive, or specialty care.

(F) Entities eligible to be funded.

(i) Proposals for funding should come from collaborations operating in one of the most distressed communities in Illinois as determined by the U.S. Centers for Disease Control and Prevention's Social Vulnerability Index for Illinois and areas disproportionately impacted by COVID-19 or from rural areas of Illinois.

(ii) The Department shall prioritize partnerships from distressed communities, which include Business Enterprise Program certified vendors or other entities controlled and managed by minorities or women and also include one or more of the following: safety-net hospitals, critical access hospitals, the campuses of hospitals that have closed since January 1, 2018, or other healthcare providers designed to address specific healthcare disparities, including the impact of COVID-19 on individuals and the community and the need for post-COVID care. All funded proposals must include specific measurable goals and metrics related to improved outcomes and

1 reduced disparities which shall be tracked by the
2 Department.
3 (iii) The Department should target the funding
4 in the following ways: $30,000,000 of
5 transformation funds to projects that are a
6 collaboration between a safety-net hospital,
7 particularly community safety-net hospitals, and
8 other providers and designed to address specific
9 healthcare disparities, $20,000,000 of
10 transformation funds to collaborations between
11 safety-net hospitals and a larger hospital partner
12 that increases specialty care in distressed
13 communities, $30,000,000 of transformation funds
14 to projects that are a collaboration between
15 hospitals and other providers in distressed areas
16 of the State designed to address specific
17 healthcare disparities, $15,000,000 to
18 collaborations between critical access hospitals
19 and other providers designed to address specific
20 healthcare disparities, and $15,000,000 to
21 cross-provider collaborations designed to address
22 specific healthcare disparities, and $5,000,000 to
23 collaborations that focus on workforce
24 development.
25 (iv) The Department may allocate up to
26 $5,000,000 for planning, racial equity analysis,

or consulting resources for the Department or entities without the resources to develop a plan to meet the criteria of this Section. Any contract for consulting services issued by the Department under this subparagraph shall comply with the provisions of Section 5-45 of the State Officials and Employees Ethics Act. Based on availability of federal funding, the Department may directly procure consulting services or provide funding to the collaboration. The provision of resources under this subparagraph is not a guarantee that a project will be approved.

(v) The Department shall take steps to ensure that safety-net hospitals operating in under-resourced communities receive priority access to hospital and healthcare transformation funds, including consulting funds, as provided under this Section.

(G) Process for submitting and approving projects for distressed communities. The Department shall issue a template for application. The Department shall post any proposal received on the Department's website for at least 2 weeks for public comment, and any such public comment shall also be considered in the review process. Applicants may request that proprietary financial information be redacted from publicly posted

1 proposals and the Department in its discretion may
2 agree. Proposals for each distressed community must
3 include all of the following:
4 (i) A detailed description of how the project
5 intends to affect the goals outlined in this
6 subsection, describing new interventions, new
7 technology, new structures, and other changes to
8 the healthcare delivery system planned.
9 (ii) A detailed description of the racial and
10 ethnic makeup of the entities' board and
11 leadership positions and the salaries of the
12 executive staff of entities in the partnership
13 that is seeking to obtain funding under this
14 Section.
15 (iii) A complete budget, including an overall
16 timeline and a detailed pathway to sustainability
17 within a 5-year period, specifying other sources
18 of funding, such as in-kind, cost-sharing, or
19 private donations, particularly for capital needs.
20 There is an expectation that parties to the
21 transformation project dedicate resources to the
22 extent they are able and that these expectations
23 are delineated separately for each entity in the
24 proposal.
25 (iv) A description of any new entities formed
26 or other legal relationships between collaborating

1 entities and how funds will be allocated among
2 participants.
3 (v) A timeline showing the evolution of sites
4 and specific services of the project over a 5-year
5 period, including services available to the
6 community by site.
7 (vi) Clear milestones indicating progress
8 toward the proposed goals of the proposal as
9 checkpoints along the way to continue receiving
10 funding. The Department is authorized to refine
11 these milestones in agreements, and is authorized
12 to impose reasonable penalties, including
13 repayment of funds, for substantial lack of
14 progress.
15 (vii) A clear statement of the level of
16 commitment the project will include for minorities
17 and women in contracting opportunities, including
18 as equity partners where applicable, or as
19 subcontractors and suppliers in all phases of the
20 project.
21 (viii) If the community study utilized is not
22 the study commissioned and published by the
23 Department, the applicant must define the
24 methodology used, including documentation of clear
25 community participation.
26 (ix) A description of the process used in

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

1 the impact of COVID-19 and the need for post-COVID
2 care in the community, if applicable.
3 (xv) An explanation of how the proposal is
4 designed to increase access to care, including
5 specialty care based upon the community's needs.
6 (H) The Department shall evaluate proposals for
7 compliance with the criteria listed under subparagraph
8 (G). Proposals meeting all of the criteria may be
9 eligible for funding with the areas of focus
10 prioritized as described in item (ii) of subparagraph
11 (F). Based on the funds available, the Department may
12 negotiate funding agreements with approved applicants
13 to maximize federal funding. Nothing in this
14 subsection requires that an approved project be funded
15 to the level requested. Agreements shall specify the
16 amount of funding anticipated annually, the
17 methodology of payments, the limit on the number of
18 years such funding may be provided, and the milestones
19 and quality metrics that must be met by the projects in
20 order to continue to receive funding during each year
21 of the program. Agreements shall specify the terms and
22 conditions under which a health care facility that
23 receives funds under a purchase of care agreement and
24 closes in violation of the terms of the agreement must
25 pay an early closure fee no greater than 50% of the
26 funds it received under the agreement, prior to the

1 Health Facilities and Services Review Board
2 considering an application for closure of the
3 facility. Any project that is funded shall be required
4 to provide quarterly written progress reports, in a
5 form prescribed by the Department, and at a minimum
6 shall include the progress made in achieving any
7 milestones or metrics or Business Enterprise Program
8 commitments in its plan. The Department may reduce or
9 end payments, as set forth in transformation plans, if
10 milestones or metrics or Business Enterprise Program
11 commitments are not achieved. The Department shall
12 seek to make payments from the transformation fund in
13 a manner that is eligible for federal matching funds.

14 In reviewing the proposals, the Department shall
15 take into account the needs of the community, data
16 from the study commissioned by the Department from the
17 University of Illinois-Chicago if applicable, feedback
18 from public comment on the Department's website, as
19 well as how the proposal meets the criteria listed
20 under subparagraph (G). Alignment with the
21 Department's overall strategic initiatives shall be an
22 important factor. To the extent that fiscal year
23 funding is not adequate to fund all eligible projects
24 that apply, the Department shall prioritize
25 applications that most comprehensively and effectively
26 address the criteria listed under subparagraph (G).

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

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

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

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

1 5A-2 that is in effect on December 31, 2017 remains in effect.
2 (g) Notwithstanding subsections (a) through (f) of this
3 Section and notwithstanding the changes authorized under
4 Section 5-5b.1, any updates to the system shall not result in
5 any diminishment of the overall effective rates of
6 reimbursement as of the implementation date of the new system
7 (July 1, 2014). These updates shall not preclude variations in
8 any individual component of the system or hospital rate
9 variations. Nothing in this Section shall prohibit the
10 Department from increasing the rates of reimbursement or
11 developing payments to ensure access to hospital services.
12 Nothing in this Section shall be construed to guarantee a
13 minimum amount of spending in the aggregate or per hospital as
14 spending may be impacted by factors, including, but not
15 limited to, the number of individuals in the medical
16 assistance program and the severity of illness of the
17 individuals.
18 (h) The Department shall have the authority to modify by
19 rulemaking any changes to the rates or methodologies in this
20 Section as required by the federal government to obtain
21 federal financial participation for expenditures made under
22 this Section.
23 (i) Except for subsections (g) and (h) of this Section,
24 the Department shall, pursuant to subsection (c) of Section
25 5-40 of the Illinois Administrative Procedure Act, provide for
26 presentation at the June 2014 hearing of the Joint Committee

on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

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

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

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

(Source: P.A. 101-81, eff. 7-12-19; 101-650, eff. 7-7-20; 101-655, eff. 3-12-21; 102-682, eff. 12-10-21; 102-1037, eff.

6-2-22; revised 8-22-22.)

(305 ILCS 5/14-12.5 new)

Sec. 14-12.5. Hospital preservation and stabilization rate update.

(a) Notwithstanding any other provision of this Code, the hospital rates of reimbursement authorized under Sections 5-5.05, 14-12, and 14-13 of this Code shall be adjusted in accordance with the provisions of this Section.

(b) Notwithstanding any other provision of this Code, effective for dates of service on and after January 1, 2024, hospital reimbursement rates shall be revised as follows:

(1) For inpatient general acute care services, the statewide-standardized amount in effect January 1, 2023 as published by the Department on December 1, 2022, shall be increased by 20%.

(2) For inpatient psychiatric services:

(A) For safety-net hospitals, the per diem rates in effect January 1, 2023, shall be increased by 20%, and the minimum per diem rate of $630, authorized in subsection (b-5) of Section 5-5.05 of this Code, shall be increased by 20%.

(B) For all general acute care hospitals that are not safety-net hospitals, the per diem rates in effect January 1, 2023 shall be increased by 20%, except that all rates shall be at least 90% of the minimum

1 inpatient per diem rate for safety-net hospitals as
2 authorized in subsection (b-5) of Section 5-5.05 of
3 this Code, including the adjustment authorized in this
4 Section.
5 (C) For all psychiatric specialty hospitals, the
6 per diem rates in effect January 1, 2023, shall be
7 increased by 20%, and the statewide default per diem
8 rates for new psychiatric specialty hospitals shall be
9 increased by 20%.
10 (3) For inpatient rehabilitative services, the per
11 diem rates in effect January 1, 2023, shall be increased
12 by 20%, and the statewide default inpatient rehabilitative
13 services per diem rates, for general acute care hospitals
14 and for rehabilitation specialty hospitals respectively,
15 shall be increased by 20%.
16 (4) The statewide-standardized amount for outpatient
17 general acute care services in effect January 1, 2023, as
18 published by the Department on December 1, 2022, shall be
19 increased by 20%.
20 (5) The statewide-standardized amount for outpatient
21 psychiatric care services in effect January 1, 2023, as
22 published by the Department on December 1, 2022, shall be
23 increased by 20%.
24 (6) The statewide-standardized amount for outpatient
25 rehabilitative care services in effect January 1, 2023, as
26 published by the Department on December 1, 2022, shall be

increased by 20%.

(7) The per diem rate in effect January 1, 2023, as authorized in subsection (a) of Section 14-13 shall be increased by 20%.

(8) The per diem add-on payment for safety-net hospitals authorized in paragraph (6) of subsection (a) of Section 14-12, as in effect on January 1, 2023, shall be increased to $115.

(c) Beginning on January 1, 2025 and each January 1 thereafter, all rates identified in paragraphs (1) through (8) of subsection (b) in effect December 31st of the year preceding the January 1 adjustment shall be increased based on the annual increase in the national hospital market basket price proxies (DRI) hospital cost index from the midpoint of the calendar year 2 years prior to the current year, to the midpoint of the preceding calendar year. In no instance shall the adjustment required in this subsection result in a reduction to the rates in place at the time of the required adjustment.

(d) If the federal Centers for Medicare and Medicaid Services finds that the increases required under this Section would result in rates of reimbursement which exceed the federal maximum limits applicable to hospital payments, then the payments and assessment tax authorized under Article V-A of this Code shall be reduced in accordance with Section 5A-15 of this Code.

1 (e) The Department shall promptly take all actions
2 necessary to ensure the changes authorized in this amendatory
3 Act of the 103rd General Assembly are in effect for dates of
4 service on and after January 1, 2024, including publishing all
5 appropriate public notices, applying for federal approval of
6 amendments to the Illinois Title XIX State Plan, and adopting
7 administrative rules if necessary.
8 (f) The Department of Healthcare and Family Services may
9 adopt rules necessary to implement the changes made by this
10 amendatory Act of the 103rd General Assembly through the use
11 of emergency rulemaking in accordance with Section 5-45 of the
12 Illinois Administrative Procedure Act. The 24-month limitation
13 on the adoption of emergency rules does not apply to rules
14 adopted under this Section. The General Assembly finds that
15 the adoption of rules to implement the changes made by this
16 amendatory Act of the 103rd General Assembly is deemed an
17 emergency and necessary for the public interest, safety, and
18 welfare.
19 (g) The Department shall ensure that all necessary
20 adjustments to the managed care organization capitation base
21 rates necessitated by the adjustments in this Section are
22 completed, published, and applied in accordance with Section
23 5-30.8 of this Code 90 days prior to the implementation date of
24 the changes required under this amendatory Act of the 103rd
25 General Assembly.

(305 ILCS 5/14-13)

Sec. 14-13. Reimbursement for inpatient stays extended beyond medical necessity.

(a) By October 1, 2019, the Department shall by rule implement a methodology effective for dates of service July 1, 2019 and later to reimburse hospitals for inpatient stays extended beyond medical necessity due to the inability of the Department or the managed care organization in which a recipient is enrolled or the hospital discharge planner to find an appropriate placement after discharge from the hospital. The Department shall evaluate the effectiveness of the current reimbursement rate for inpatient hospital stays beyond medical necessity.

(a-5) By October 1, 2023, the Department shall by rule implement a methodology effective for dates of service beginning on and after January 1, 2024 to reimburse hospitals for extended stays in a hospital emergency department due to the inability of the Department or the managed care organization in which a recipient is enrolled or the hospital discharge planner to find an appropriate placement or transfer to an appropriate facility other than the hospital to which the patient presented. The per diem rate established shall be equal to 2 times the per diem rate paid for stays identified in subsection (a), prorated in hourly increments for each new hour beyond the 4th hour after the time that the patient is determined to be ready for transfer or admission. The rate

established under this subsection shall be paid based on the entire length of the stay in the hospital emergency department awaiting transfer.

(b) The methodology shall provide reasonable compensation for the services provided attributable to the days of the extended stay for which the prevailing rate methodology provides no reimbursement. The Department may use a day outlier program to satisfy this requirement. The reimbursement rate shall be set at a level so as not to act as an incentive to avoid transfer to the appropriate level of care needed or placement, after discharge.

(c) The Department shall require managed care organizations to adopt this methodology or an alternative methodology that pays at least as much as the Department's adopted methodology unless otherwise mutually agreed upon contractual language is developed by the provider and the managed care organization for a risk-based or innovative payment methodology.

(d) Days beyond medical necessity shall not be eligible for per diem add-on payments under the Medicaid High Volume Adjustment (MHVA) or the Medicaid Percentage Adjustment (MPA) programs.

(e) For services covered by the fee-for-service program, reimbursement under this Section shall only be made for days beyond medical necessity that occur after the hospital has notified the Department of the need for post-discharge

1 placement. For services covered by a managed care
2 organization, hospitals shall notify the appropriate managed
3 care organization of an admission within 24 hours of
4 admission. For every 24-hour period beyond the initial 24
5 hours after admission that the hospital fails to notify the
6 managed care organization of the admission, reimbursement
7 under this subsection shall be reduced by one day.
8 (Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21.)

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

INDEX

Statutes amended in order of appearance

5 ILCS 100/5-45.35 new
305 ILCS 5/5-5.05
305 ILCS 5/14-12
305 ILCS 5/14-12.5 new
305 ILCS 5/14-13