Review of the Hospital Assessment Program During the Time Period of July 2020 Through December 2021

A Report to the Members of the 102nd General Assembly of the State of Illinois

Table of Contents

Section	Page
Executive Summary	3
Directed Payment Types and Hospital Classifications	4
Review of Payments	5
Tax Adjustments	7
Other Information as Requested in Legislation	8

Executive Summary

The hospital assessment program (HAP) implemented on July 1, 2020 initiated several changes from the previous versions of the HAP. Namely, the payment programs were structured into directed payments and passthrough payments per federal requirements and the tax was structured to adjust. Three types of directed payments, Fixed Pool, Fixed Rate, and Acuity Based Fixed Rate, were created and applicable to different classes of hospitals. This is the first time that aggregate payment amounts were not frozen to historical service levels but can fluctuate with higher or lower volumes of services. While the structure of the hospital tax did not change, the Department was given authority to update the tax on an annual or semi-annual basis to account for the fluctuations in aggregate payment amounts.

Even in the midst of a health emergency that saw postponements of elective surgeries during an extended amount of time, payments over the first 18 months were higher than originally modeled for several reasons. First, actual volumes were higher than modeled. Outpatient volumes across all hospital classifications were below modeled volumes for claims adjudications during the quarter April to June 2020, due to the aforementioned postponements of elective procedures. However, several factors including the following led to higher overall utilization:

- Inclusion of claims from previous time periods that were adjudicated during the data collection period
- Rise in Medicaid enrollment during the health emergency
- Pent up demand for postponed services eventually caught up in 2021

The higher than expected utilization levels resulted in higher than expected payment levels to the total amount of $386 million over the original modeled estimates. The over payments are funded through uniform increases in the hospital tax calculated by the Department in accordance with legislation.

Each year the federal government requires a reduction of passthrough payments, or payments that are not directly tied to specified utilization. The Department met that requirement in January 2021 and January 2022, with the reduction of passthrough payments being shifted to an increase in directed payments rates and fixed pool amounts.

This report gives more detail behind the HAP experience during the past 18 months and offers additional information as requested in Public Act 101-0650

Directed Payment Types and Hospital Classifications

In order to comply with recent federal guidelines pertaining to payments made to Managed Care Organizations (MCOs) outside of monthly capitation payments, that are then paid to hospitals, the Department was required to tie a portion of the payments to recent hospital utilization. On a quarterly basis, the Department analyzes paid claims data received from the MCO's from a recent quarter and applies the following methodologies to determine payment.

Fixed Pools

In order to provide more stability in payments and guard against fluctuations in quarterly utilization data, fixed pools of money were established for Safety Net and Critical Access hospitals. For each quarter, a given pool amount for inpatient services is divided by the total number of inpatient days for all hospitals in the classification to get a per day rate. Each hospital receives the per day rate times their covered days. Similarly, a given outpatient pool amount for outpatient services is divided by the total number of outpatient claims for all hospitals in the classification to get a per claim rate. Each hospital receives the per claim rate times their number of outpatient claims. Each quarter, the same amount in aggregate is paid out, however the payment amount to individual hospitals within the classification can vary based on each hospitals' utilization data.

Fixed Rate

Specialty hospitals were grouped into three different classifications including free-standing psychiatric hospitals, free-standing rehabilitation hospitals, and long term acute care hospitals, and a standard rate per unit methodology was established for their directed payments. For inpatient services, a fixed per day rate is multiplied by the number of covered days recorded during the quarter for each provider in the classification. Similarly, a fixed rate is multiplied by the number of outpatient claims recorded during the quarter for each provider. The long term acute care hospital classification did not have an outpatient payment rate. Aggregate quarterly payments will fluctuate based on volumes of claims recorded.

Acuity Adjusted Fixed Rate

For general acute care hospitals, a methodology that considers the acuity of each hospital's claims was created for two new classifications of hospitals, High Medicaid Hospitals and Other Acute Hospitals. High Medicaid Hospitals are defined as those with an Medicaid Inpatient Utilization Rate greater than or equal to 30% or a total annual number of Medicaid Inpatient days over 35,000. Hospitals that do not meet those criteria are considered Other Acute Hospitals. Each individual hospital's inpatient payment is derived from multiplying the number of inpatient admissions by the case mix (the total relative weight assigned to all admissions divided by the number of admissions), and multiplied by a fixed rate. This occurs for each category of service, acute care, psychiatric care, and rehabilitation care. The outpatient

payment is derived by multiplying each individual hospitals' total number of paid EAPG's (service lines on a given outpatient claim that receives payment) by the case mix (total relative weight assigned to all paid EAPGs divided by the number of EAPGs) and multiplied by a fixed rate for each category of service. Aggregate quarterly payments will fluctuate based on volumes and acuity of claims recorded.

Review of Payments

For the period of July 1, 2020 through December 31, 2021, the aggregate payment amount to hospitals was higher than anticipated due to a higher volume of claims than estimated. However, the payment methodologies performed as anticipated with the hospitals in fixed pools having stable payment levels and the hospitals in the non-fixed pools realizing fluctuating payments with the varying volumes of claims during each quarter. No hospital in the fixed pool classifications received less than 95% of original modeled estimates over the 18 month period.

The following charts display the original modeled payment amounts and the actual payment amounts by hospital classification. The charts are split by time periods of July 2020 through December 2020 and January 2021 through December 2021 due to the January 1, 2021 change in classifications of hospitals and updating of rates and fixed pool amounts.

Chart 1: July 2020 – December 2020 Payments Compared to Model

	Modeled			Actual			
Classification	**Directed Payment**	**Passthrough**	**Total**	**Directed Payment**	**Passthrough**	**Total**	**Difference**
Safety Net	$ 128,301,098	$195,243,548	$ 323,544,645	$ 128,301,096	$195,243,548	$ 323,544,644	$ (2) *
Critical Access	$ 14,377,750	$ 31,276,943	$ 45,654,693	$ 14,377,748	$ 31,276,943	$ 45,654,691	$ (2) *
High Medicaid	$ 217,042,681	$172,510,719	$ 389,553,400	$ 245,363,485	$172,510,719	$ 417,874,204	$28,320,805
Other Acute	$ 209,410,241	$275,714,535	$ 485,124,776	$ 221,846,310	$275,714,535	$ 497,560,845	$12,436,069
Psych FS	$ 15,893,935	$ 20,412,722	$ 36,306,657	$ 20,676,380	$ 20,412,722	$ 41,089,102	$ 4,782,445
Rehab FS	$ 3,555,910	$ 4,826,054	$ 8,381,964	$ 3,573,320	$ 4,826,054	$ 8,399,374	$ 17,410
LTAC	$ 7,796,993	$ 13,641,935	$ 21,438,928	$ 11,718,135	$ 13,641,935	$ 25,360,070	$ 3,921,143
Total	**$ 596,378,607**	**$713,626,456**	**$1,310,005,063**	**$ 645,856,474**	**$713,626,456**	**$1,359,482,930**	**$49,477,867**

*Due to Rounding

In December 2020, the Department redetermined the hospitals' classifications utilizing more recent MIUR's and utilization data. In addition, per federal requirements, passthrough payments were reduced in aggregate by $200M as seen in Chart 2 below. To achieve this, a 16% reduction was applied uniformly across all hospitals. Directed payment fixed pools and rates were increased to move the reduction of passthrough payments into directed payments. Outpatient rates for the non-fixed pool methodologies were not adjusted due to the combination of 1) the certainty that outpatient claims volumes would go

up with the newly included NIPS claims and 2) the uncertainty of the volume of the increase and the reduction to case mix. The resulting payments in calendar year 2021 exceeded the modeled payments by $336M, with $70 million excess paid from January through June and $266 million excess paid from July through December.

Chart 2: Calendar Year 2021 Payments Compared to Model

	Modeled			Actual			
Classification	**Directed Payment**	**Passthrough**	**Total**	**Directed Payment**	**Passthrough**	**Total**	**Difference**
Safety Net	$ 262,303,810	$ 395,105,710	$ 657,409,521	$ 340,669,710	$ 339,739,810	$ 680,409,521	$ 23,000,000 **
Critical Access	$ 28,755,500	$ 62,553,886	$ 91,309,386	$ 40,321,134	$ 53,788,252	$ 94,109,386	$ 2,800,000 **
High Medicaid	$ 475,750,881	$ 384,137,853	$ 859,888,734	$ 711,394,715	$ 330,308,872	$ 1,041,703,587	$ 181,814,853
Other Acute	$ 371,453,347	$ 507,694,040	$ 879,147,387	$ 557,579,276	$ 436,551,212	$ 994,130,488	$ 114,983,101
Psych FS	$ 31,787,870	$ 40,825,444	$ 72,613,314	$ 46,300,176	$ 35,104,602	$ 81,404,778	$ 8,791,464
Rehab FS	$ 7,111,820	$ 9,652,108	$ 16,763,928	$ 12,389,706	$ 8,299,564	$ 20,689,271	$ 3,925,343
LTAC	$ 15,593,985	$ 27,283,870	$ 42,877,855	$ 20,497,455	$ 23,460,600	$ 43,958,055	$ 1,080,199
Total	**$ 1,192,757,214**	**$ 1,427,252,912**	**$ 2,620,010,125**	**$ 1,729,152,174**	**$ 1,227,252,912**	**$ 2,956,405,086**	**$ 336,394,960**

**Amounts added to fixed pools to account for volume increases

As described in the next section, a uniform tax increase to fund overpayments is levied across all tax paying hospitals. For hospitals in a fixed pool, that tax increase devalued their pool. After analysis of utilization data by class, the Safety Net and Critical Access Hospital classifications experienced increases in utilization that mirrored the other classifications. Therefore, funding was added to the fixed pools, above the amount transferred from the reduction of passthrough payments to account for the increase in utilization.

Chart 3 below displays the inpatient per day value and outpatient per claim value across all classifications when including all utilization based payments, the fee-for-service supplemental payments and the directed payments, issued under the HAP during the 18 month period.

Chart 3: Payment Per Unit by Hospital Classification

Class	IP Per Day	OP Per Claim
Safety Net	$ 682.09	$ 742.76
High Medicaid	$ 571.98	$ 562.76
Other Acute	$ 492.95	$ 500.71
Critical Access	$2,621.85	$ 401.05
Psych FS	$ 240.09	$ 260.83
Rehab FS	$ 456.36	$ -

Tax Adjustments

By introducing the fixed rates and acuity based fixed rates methodologies to the directed payment portion of the HAP, aggregate payment amounts will fluctuate and may result in the state's financial liability to be higher or lower than the amount of the hospital tax assessed to fund those payments. To solve for this, the Department may adjust the tax on an annual or semi-annual basis by subtracting the modeled payments from the actual payments during the previous assessment period and multiplying by .3853 to account for the State's estimated liability for the payments.

For the period of July 2020 through December 2020, per Chart 1, the amount of actual payments over the modeled amount was $49,477,867. Therefore, the tax adjustment was an increase of $19,063,822. The tax increase was split evenly over the inpatient tax and the outpatient tax by uniform increases across all hospitals that pay the assessment. Due to the requirement in legislation to notify hospitals of the tax increase 30 days prior to the change, the uniform percentage was increased to collect the $19 million over five months instead of six.

Chart 4: Initial Tax Increase Calculation

Actual Payments 7/1/2020 – 12/30/2020:	$1,359,482,930
Less Modeled Payments:	- $1,310,005,063
Payment in Excess:	$49,477,867
	x .3853
Tax Increase:	$19,063,822

In July 2021, no adjustment to the tax was applied. The Department carried forward the tax at the level in place in June 2021 over the next six months to fund the $70 million in excess payments during the months of January 2021 through June 2021.

Directed payments during the months of July 2021 through December 2021 were based on claims data adjudicated between January 2021 and June 2021. Claims volumes were much higher due to pent-up demand for services previously postponed and the increase in Medicaid enrollment since the start of the health emergency. Inpatient units were 34% higher than the original modeled utilization and 20% higher than the previous six months adjudications. Outpatient services were much higher as well, but partially due to the inclusion of NIPS claims into the directed payment calculations as well as increased utilization. Aggregate payment for this period totaled $266 million more than modeled. To fund these payments, the tax adjustment implemented January 2022 is detailed below in Chart 5.

Chart 5: Tax Increase Calculation for 1/1/22

Actual Payments 7/1/2021 – 12/30/2021:	$1,576,211,092
Less Modeled Payments:	- $1,310,005,063
Payment in Excess:	$266,206,029
	x .3853
Tax Increase:	$102,569,183

Other Information Requested in Public Act

Per Public Act 101-0652, after consulting the hospital community and other interested parties, the Department shall provide information that summarizes and identifies options and stakeholder suggestions on the following:

Policies and practices to improve access to care, improve health, and reduce health disparities in vulnerable communities.

Public Acts 101-650 and Public Act 101-0655 created the Hospital and Healthcare Transformation Program otherwise known as Healthcare Transformation Collaboratives (HTC). HTC is designed to encourage collaborations of healthcare providers and community partners to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities throughout Illinois. In particular, the program seeks to increase access to community-based services, preventive care, obstetric care, chronic disease management, specialty care and address the social determinants of health in these communities.

Analysis of charity care by hospital.

A hospital's charity care percentage is defined as the ratio of the hospitals charity charges for services provided to individuals without health insurance or another source of third party coverage to the Illinois total hospital charges. Hospitals report charity care to the Department annually, however, while charity care is a criteria used to qualify for Safety Net status, many hospitals do not submit the information. Appendix 1 lists the last two year's charity care percentages by hospital. Hospitals that do not submit charity care information are listed with 0.0%.

Revisions of the payment methodology for GME.

Graduate Medical Education (GME) refers to the hospital based training programs including internship, residency, and subspecialty and fellowship programs that leads to state licensure and board certification. The Department currently invests over $104 million in GME payments to 57 hospitals across Illinois. All hospitals that reported intern and resident cost on their 2018 Medicare cost reports currently qualify for a GME payment. The Department is looking at possible revisions to the payment methodology for GME including the qualifying criteria and the level of funding for the GME program.

Revisions to the directed payment methodologies, including the opportunity for hospitals to shift from the fixed pool to the fixed rate directed payments.

The Department is currently taking into consideration options for revising the directed payment methodologies. Hospitals are weighing the stability of the aggregate fixed pool approach with the uncertainty of the service volumes occurring at other hospitals in the pool, which determines the individual hospital payment levels. As the transfer of passthrough dollars to directed payments continues, the concern for those hospitals with larger passthrough dollars becomes more relative.

The Department is looking into options of allowing hospitals to choose which methodology that would prefer in the case that they could qualify for multiple hospital classifications. That choice would have to be made prior to each calendar year and could not be reversed mid-year.

The definitions of and criteria to qualify as a safety net hospital, a high Medicaid hospital, or a children's hospital.

The Department is currently analyzing options for revisions to hospital classifications as they apply to the directed payments. Updating qualification criteria is being considered in part to assist in meeting federal requirements related to aggregate payment levels within each classification. Options including incorporating outpatient volumes, taking regional locations into account, and varying thresholds for the Medicaid inpatient utilization rate (MIUR) are examples of adjustments that could be applied to qualification criteria or the creation of new hospital classifications.

In addition, the Department requested that the Medicaid Advisory Committee's subcommittee on Health Equity and Quality (HE&Q), make a recommendation regarding the creation of a subcategory of a Safety Net Hospital designation titled Community Safety Net Hospital. The subcommittees recommendations can be found in Appendix 2 of this report.

Options to revise the methodology for calculating the assessment under section 5A-2.

The current hospital assessment is comprised of a combination of two taxes, a tax on inpatient bed days and outpatient gross revenues, both as reported on hospitals 2015 cost reports. The first and most practicable revision to the assessment would be to update to the 2019 cost reports. This would allow the tax to be more reflective of current utilization levels as utilization has shifted among hospitals since 2015. While 2020 cost reports may be available at the time of the next update, the Department would advise using 2019 cost reports to avoid any anomalies that may be present in the 2020 cost reports due

to the Covid-19 pandemic. If updating every 3 or 4 years, the next update would presumably be based on 2022 or 2023 cost reports that would reflect the normalization of cost reports accounting for the effects of the pandemic across the industry.

Another option brought to the Department is to revise the inpatient tax to be similar to the outpatient, based on inpatient gross revenues. This option may have one drawback in that the percentage of the tax that can be attributed to Medicaid can be allocated to Medicaid cost when the Department calculates the upper payment limits for fee-for-service payment demonstrations to the federal government. To the extent that the Medicaid percentage of gross revenue would likely be less than the Medicaid percentage of inpatient bed days, this could have an impact on the total amount of Medicaid cost that can be incorporated into the upper payment limit.

Appendix 1: Charity Care Percentages

Hospital Name	CITY	2022 Charity Percentage	2021 Charity Percentage
Abraham Lincoln Memorial Hosp	LINCOLN	0.00%	0.00%
Advocate BroMenn Medical Center	NORMAL	0.00%	0.00%
Advocate Christ Medical Center	OAK LAWN	1.51%	1.06%
Advocate Condell Medical Center	LIBERTYVILLE	2.52%	2.13%
Advocate Eureka Hospital	EUREKA	0.00%	0.00%
Advocate Good Samaritan Hosp	DOWNERS GROVE	1.35%	1.05%
Advocate Good Shepherd Hospital	BARRINGTON	0.83%	0.59%
Advocate Illinois Masonic MC	CHICAGO	2.37%	1.78%
Advocate Lutheran General Hosp	PARK RIDGE	1.69%	1.25%
Advocate Sherman Hospital	ELGIN	2.22%	1.50%
Advocate South Suburban Hosp	HAZEL CREST	1.80%	1.06%
Advocate Trinity Hospital	CHICAGO	3.30%	1.86%
Alton Memorial Hospital	ALTON	1.84%	0.71%
AMITA Adventist MC-Bolingbrook	BOLINGBROOK	1.92%	1.71%
AMITA Adventist MC-GlenOaks	GLENDALE HEIGHTS	3.08%	2.77%
AMITA Adventist MC-Hinsdale	HINSDALE	0.54%	0.46%
AMITA Adventist MC-La Grange	LAGRANGE	1.21%	0.95%
AMITA Hlth Alexian Bros BH Hosp	HOFFMAN ESTATES	0.76%	0.81%
AMITA Hlth Alexian Bros Med Ctr	ELK GROVE VILLAGE	0.00%	0.92%
AMITA Hlth St Alexius Med Ctr	HOFFMAN ESTATES	3.08%	1.43%
Anderson Hospital	MARYVILLE	0.00%	0.52%
Ann & Robert H Lurie Child Hosp	CHICAGO	0.22%	0.25%
Blessing Hospital	QUINCY	2.08%	1.73%
Carle Foundation Hospital	URBANA	1.74%	2.18%
Carle Hoopeston Region Hlth Ctr	HOOPESTON	0.00%	0.00%
Carlinville Area Hospital	CARLINVILLE	0.00%	0.00%
Centegra Hospital-McHenry	McHENRY	1.42%	1.30%
CGH Medical Center	STERLING	0.17%	0.21%
Chicago Behavioral Hospital	DES PLAINES	0.08%	0.00%
Clay County Hospital	FLORA	0.00%	0.00%
Community First Medical Center	CHICAGO	6.62%	4.67%
Community Hospital of Staunton	STAUNTON	0.00%	0.00%
Crawford Memorial Hospital	ROBINSON	0.00%	0.00%

Appendix 1: Charity Care Percentages

Hospital Name	CITY	2022 Charity Percentage	2021 Charity Percentage
Crossroads Community Hospital	MOUNT VERNON	1.18%	0.86%
Decatur Memorial Hospital	DECATUR	0.00%	0.00%
Edward Hospital	NAPERVILLE	0.92%	1.08%
Elmhurst Hospital	ELMHURST	1.04%	1.29%
Fairfield Memorial Hospital	FAIRFIELD	0.00%	0.00%
Fayette County Hospital & LTC	VANDALIA	0.00%	0.00%
Ferrell Hospital	ELDORADO	0.00%	0.00%
FHN Memorial Hospital	FREEPORT	0.07%	0.06%
Franciscan Health Oly Fl/Chg	OLYMPIA FIELDS	3.79%	3.83%
Franklin Hospital District	BENTON	0.00%	0.94%
Galesburg Cottage Hospital	GALESBURG	0.00%	0.39%
Garfield Park Behavioral Hosp	CHICAGO	1.03%	0.03%
Gateway Regional Medical Center	GRANITE CITY	1.89%	1.74%
Genesis Medical Center	ALEDO	0.00%	0.00%
Genesis Medical Center, Silvis	SILVIS	1.47%	1.40%
Gibson Area Hosp & Hlth Servcs	GIBSON CITY	0.00%	0.00%
Good Samaritan Region Hlth Ctr	MOUNT VERNON	0.76%	0.58%
Gottlieb Memorial Hosp	MELROSE PARK	0.12%	0.58%
Graham Hospital	CANTON	0.59%	0.89%
Hamilton Memorial Hosp District	McLEANSBORO	0.00%	0.00%
Hammond-Henry Hospital	GENESEO	0.00%	0.00%
Hardin County General Hospital	ROSICLARE	2.41%	1.63%
Harrisburg Medical Center	HARRISBURG	0.52%	0.00%
Hartgrove Behavioral Health Sys	CHICAGO	0.74%	0.36%
Heartland Regional Medical Ctr	MARION	0.68%	0.68%
Herrin Hospital	HERRIN	0.80%	0.53%
Hillsboro Area Hospital	HILLSBORO	1.39%	2.17%
Holy Cross Hospital	CHICAGO	2.39%	3.88%
Hopedale Medical Complex	HOPEDALE	0.00%	0.00%
HSHS Good Shepherd Hospital	SHELBYVILLE	0.00%	0.57%
HSHS Holy Family Hospital	GREENVILLE	0.00%	1.34%
HSHS St Anthony's Memorial Hosp	EFFINGHAM	0.00%	0.00%
HSHS St Elizabeth's Hospital	BELLEVILLE	0.00%	0.00%
HSHS St Francis Hospital	LITCHFIELD	0.00%	0.00%
HSHS St John's Hospital	SPRINGFIELD	0.00%	0.00%
HSHS St Joseph's Hospital	BREESE	0.00%	0.00%
HSHS St Joseph's Hospital	HIGHLAND	0.00%	2.03%
HSHS St Mary's Hospital	DECATUR	0.00%	0.00%
Illini Community Hospital	PITTSFIELD	0.80%	0.96%
Illinois Valley Community Hosp	PERU	0.00%	0.00%

Appendix 1: Charity Care Percentages

Hospital Name	CITY	2022 Charity Percentage	2021 Charity Percentage
Ingalls Memorial Hospital	HARVEY	1.84%	1.26%
Insight Hospital and Med Ctr	CHICAGO	1.19%	1.95%
Iroquois Mem Hosp & Res Home	WATSEKA	0.00%	0.00%
Jackson Park Hospital & Med Ctr	CHICAGO	4.74%	5.97%
Jersey Community Hospital	JERSEYVILLE	0.00%	0.00%
Katherine Shaw Bethea Hospital	DIXON	0.00%	0.00%
Kindred Chicago Central Hosp	CHICAGO	0.00%	0.00%
Kindred Hosp Chicago Northlake	NORTHLAKE	0.00%	0.08%
Kindred Hospital Peoria	PEORIA	0.00%	0.00%
Kindred Hospital Sycamore	SYCAMORE	0.00%	0.00%
Kirby Medical Center	MONTICELLO	0.00%	0.00%
La Rabida Children's Hospital	CHICAGO	0.00%	0.00%
Lake Behavioral Health	WAUKEGAN	1.07%	0.00%
Lawrence County Memorial Hosp	LAWRENCEVILLE	0.00%	0.00%
Lincoln Prairie Beh Health Ctr	SPRINGFIELD	1.14%	0.00%
Linden Oaks Behavioral Health	NAPERVILLE	2.03%	1.88%
Little Co of Mary Hosp & HCC	EVERGREEN PARK	3.08%	1.26%
Loretto Hospital	CHICAGO	2.20%	1.97%
Loyola University Med Center	MAYWOOD	0.33%	0.37%
MacNeal Hospital	BERWYN	1.70%	1.29%
Marshall Browning Hospital	DUQUOIN	0.00%	0.00%
Mason District Hospital	HAVANA	0.00%	0.22%
Massac Memorial Hospital	METROPOLIS	0.00%	0.00%
McDonough District Hospital	MACOMB	0.00%	0.00%
Memorial Hosp of Carbondale	CARBONDALE	0.99%	0.75%
Memorial Hospital	CARTHAGE	0.68%	0.38%
Memorial Hospital	BELLEVILLE	1.39%	0.65%
Memorial Hospital	CHESTER	0.00%	0.00%
Memorial Hospital East	SHILOH	0.97%	0.67%
Memorial Medical Center	SPRINGFIELD	0.38%	0.35%
Mercyhealth Hosp-Harvard Campus	HARVARD	0.00%	0.00%
Mercyhealth Hosp-Rockton Ave	ROCKFORD	0.29%	0.62%
Methodist Hospital of Chicago	CHICAGO	0.00%	0.00%
Midwest Medical Center	GALENA	0.00%	0.00%
Midwestern Regional Med Ctr	ZION	0.00%	0.00%
Morris Hospital & Hlthcare Ctrs	MORRIS	1.43%	1.46%
Morrison Community Hospital	MORRISON	0.00%	0.00%
Mount Sinai Hospital	CHICAGO	7.83%	8.06%
NorthShore Univ HealthSystem	EVANSTON	1.14%	1.13%
Northwest Community Hospital	ARLINGTON HEIGHTS	0.00%	1.89%

Appendix 1: Charity Care Percentages

Hospital Name	CITY	2022 Charity Percentage	2021 Charity Percentage
Northwestern Memorial Hospital	CHICAGO	1.25%	1.50%
Norwegian American Hospital	CHICAGO	5.82%	4.97%
NW Med Central DuPage Hospital	WINFIELD	1.27%	1.81%
NW Med Delnor Hospital	GENEVA	0.54%	0.78%
NW Med Kishwaukee Hospital	DEKALB	0.88%	1.20%
NW Med Lake Forest Hospital	LAKE FOREST	2.00%	2.49%
NW Med Marianjoy Rehab Hospital	WHEATON	1.87%	0.92%
NW Med Valley West Hospital	SANDWICH	1.36%	1.08%
OSF Heart of Mary(Prev. Presence Covenant Med Center)	URBANA	0.96%	0.32%
OSF Holy Family Medical Center	MONMOUTH	1.97%	2.17%
OSF Sacred Heart - Danville	DANVILLE	1.69%	0.60%
OSF Saint Anthony Medical Ctr	ROCKFORD	1.40%	1.30%
OSF Saint Elizabeth Med Center	OTTAWA	1.36%	1.40%
OSF Saint Francis Medical Ctr	PEORIA	1.35%	1.06%
OSF Saint James-J W Albrecht MC	PONTIAC	1.63%	1.57%
OSF Saint Luke Medical Center	KEWANEE	2.22%	2.19%
OSF Saint Paul Medical Center	MENDOTA	1.38%	1.69%
OSF St Anthony's Health Center	ALTON	1.16%	1.15%
OSF St Joseph Medical Center	BLOOMINGTON	1.27%	1.19%
OSF St Mary Medical Center	GALESBURG	1.97%	1.69%
Palos Community Hospital	PALOS HEIGHTS	0.00%	0.00%
Pana Community Hospital	PANA	0.00%	0.00%
Paris Community Hospital	PARIS	0.00%	0.00%
Passavant Area Hospital	JACKSONVILLE	0.00%	1.25%
Perry Memorial Hospital	PRINCETON	0.00%	0.00%
Pinckneyville Community Hosp	PINCKNEYVILLE	0.58%	0.41%
Presence Holy Family Med Center	DES PLAINES	0.11%	0.36%
Presence Mercy Medical Center	AURORA	3.36%	3.42%
Presence Resurrection Med Ctr	CHICAGO	1.12%	1.07%
Presence Saint Francis Hospital	EVANSTON	1.25%	1.67%
Presence Saint Joseph Hospital	ELGIN	3.05%	2.19%
Presence Saint Joseph Hospital	CHICAGO	0.94%	0.79%
Presence Saint Joseph Med Ctr	JOLIET	1.70%	1.62%
Presence Saint Mary Hospital	CHICAGO	2.64%	1.69%
Presence St Mary's Hospital	KANKAKEE	1.55%	1.22%
Red Bud Regional Hospital	RED BUD	0.68%	0.61%
Richland Memorial Hospital	OLNEY	0.00%	0.00%
Riveredge Hospital	FOREST PARK	0.77%	0.27%
Riverside Medical Center	KANKAKEE	1.57%	1.60%
RML Specialty Hospital	HINSDALE	0.06%	0.13%

Appendix 1: Charity Care Percentages

Hospital Name	CITY	2022 Charity Percentage	2021 Charity Percentage
Rochelle Community Hospital	ROCHELLE	0.00%	0.00%
Roseland Community Hospital	CHICAGO	2.20%	2.46%
Rush Oak Park Hospital	OAK PARK	0.00%	2.44%
Rush University Medical Center	CHICAGO	0.00%	1.80%
Rush-Copley Medical Center	AURORA	0.96%	0.79%
Saint Anthony Hospital	CHICAGO	5.21%	5.51%
Salem Township Hospital	SALEM	0.00%	0.00%
Sarah Bush Lincoln Health Ctr	MATTOON	0.00%	1.74%
Sarah D Culbertson Mem Hosp	RUSHVILLE	0.12%	0.21%
Schwab Rehabilitation Hospital	CHICAGO	2.37%	2.79%
Shirley Ryan Ability Lab	CHICAGO	0.00%	0.00%
Shriners Hosps for Chld-Chicago	CHICAGO	25.65%	25.96%
Silver Cross Hospital	NEW LENOX	0.00%	0.00%
Silver Oaks Behavioral Hospital	NEW LENOX	0.75%	N/A
South Shore Hospital	CHICAGO	0.00%	0.00%
Sparta Community Hospital	SPARTA	0.00%	0.00%
St Bernard Hosp & Hlth Care Ctr	CHICAGO	3.99%	4.48%
St Joseph Memorial Hospital	MURPHYSBORO	0.71%	0.64%
St Margaret's Health	SPRING VALLEY	0.00%	1.13%
St Mary's Hospital	CENTRALIA	0.57%	0.46%
Streamwood Behavioral Hcare Sys	STREAMWOOD	0.81%	0.06%
Swedish Covenant Hospital	CHICAGO	0.00%	4.55%
SwedishAmerican Hospital	ROCKFORD	0.00%	0.00%
Taylorville Memorial Hospital	TAYLORVILLE	0.00%	0.00%
The Pavilion	CHAMPAIGN	1.10%	1.19%
Thomas H Boyd Memorial Hospital	CARROLLTON	0.21%	0.19%
Thorek Memorial Hospital	CHICAGO	0.00%	0.00%
Touchette Regional Hospital	EAST ST. LOUIS	0.00%	5.22%
Union County Hospital	ANNA	1.30%	1.01%
UnityPoint Health - Methodist	PEORIA	0.89%	0.77%
UnityPoint Health - Pekin	PEKIN	0.53%	0.64%
UnityPoint Health - Proctor	PEORIA	0.68%	0.60%
UnityPoint Health - Trinity	ROCK ISLAND	0.63%	0.48%
University of Chicago Medicine	CHICAGO	1.56%	1.19%
Van Matre HealthSouth Rehb Hsp	ROCKFORD	0.20%	0.12%
Vibra Hospsital	SPRINGFIELD	0.00%	0.00%
Vista Medical Center East	WAUKEGAN	1.97%	1.64%
Wabash General Hospital	MOUNT CARMEL	0.31%	0.06%
Warner Hospital & Health Srvcs	CLINTON	0.67%	0.37%
Washington County Hospital	NASHVILLE	0.00%	0.00%
Weiss Memorial Hosp	CHICAGO	2.51%	3.30%
West Suburban Med Ctr	OAK PARK	3.50%	3.70%

Appendix 2: Recommendation on Community Safety Net Designation

March 8, 2021

Ms. Theresa Eagleson
Director
Illinois Department of Healthcare & Family Services
201 South Grand Avenue
Springfield, IL 62706

RE: Recommendation on Community Safety Hospital Designation

Dear Director Eagleson:

The Illinois Department of Healthcare & Family Services requested that the Medicaid Advisory Committees' Subcommittee on Health Equity & Quality (HE&Q) make a recommendation regarding the creation of a subcategory of a Safety Net Hospital designation titled Community Safety Net Hospital.

The HE&Q Subcommittee met over the past few months and heard from several stakeholder organizations, interested parties and HFS executives on the matter. Presenters included the following:

1. John Bomher, Senior Vice President and Counsel, Government Relations and Policy at Illinois Health and Hospital Association
2. Tim Egan, President & CEO, The New Roseland Community Hospital on behalf of the Association of Safety-Net Community Hospitals (ASNCH)
3. Cristal Gary, Chief Advocacy Officer, AMITA Health
4. Dr. Lisa Green, CEO, Family Christian Health Center
5. Anne Igoe, Vice President and Director for Health Systems, SEIU Healthcare IL/IN
6. Dan Jenkins, Deputy Administrator of Rates and Finance, Illinois Department of Healthcare & Family Services (HFS)
7. Amber Kirchhoff, Director, Public Policy & Governmental Affairs, Illinois Primary Health Care Association (IPHCA)
8. Barbara Martin, CEO, West Suburban Medical Center
9. Ben Winick, Chief of Staff, Illinois Department of Healthcare & Family Services (HFS

Throughout our discussions we found common themes and key concepts supporting the creation of such a designation. To that end, we developed a set of criteria for Safety Net Hospitals that wish to opt-in to become designated as a Community Safety Net Hospital.

In presenting these recommendations to HFS, the HE&Q Subcommittee believes that the State of Illinois will have to provide additional funding to Safety-Net Hospitals that opt-in to become designated as Community Safety-Net Hospitals as these hospitals implement the criteria as follows.

Appendix 2: Recommendation on Community Safety Net Designation

Criteria Considerations for Opting to be a Community Safety Net Hospital:

1. The governing board must have community representation and include members with the requisite skills to provide oversight of the organization with input from the Department of Healthcare & Family Services. Governing board must be comprised of a minimum of 51% community members that could include patients or users.
2. The State shall have input into the selection and performance assessment of the senior leadership team for the organization charged with executing on the priorities. The selection and performance assessment of the senior leadership team shall be based on the agreed upon criteria that incorporates the requisite skills required to carry-out the responsibilities of the team. Performance assessments shall occur on an annual basis.
3. The hospital must create an advocacy council for community input. The role of the advocacy council shall not be fiduciary, nor shall it have oversight responsibilities of the organization, but shall primarily focus on promoting the institution and actions for equity in health outcomes.
4. The hospital must provide or create systematic arrangements for physical and behavioral health services, including follow up care linkages to higher levels of care and to a patient's primary medical care or health home, commensurate with the needs of the patient and the community.
5. The hospital must have a targeted, equity-focused approach and a plan with metrics (reviewed by the Heath Equity & Quality Subcommittee and approved by the Department) to address significant health disparities and service gaps. It must also partner with other organizations, including managed care organizations, federally qualified health centers, community-based organizations, community mental health centers, to address social and structural determinants of health in the community.
6. The hospital must partner with other well-resourced hospitals or physician groups to ensure sustainable access to services to address health disparities in the community.
7. All capital improvement requests for the hospital buildings or clinical settings must be in alignment with the HFS approved service delivery model (See number 5 above).

In furtherance of the comment regarding funding for this new hospital designation, the HE&Q Subcommittee suggests that the state should seek to expand Healthcare Transformation funding to include targeted resources, including capital improvement, for Safety-Net hospitals that opt-in and choose to meet the community safety net hospital criteria.

The Health Equity & Quality Subcommittee was honored to provide recommendations to HFS on this matter and looks forward to continuing to work with HFS on future policy recommendations.

Sincerely,

Howard A. Peters
Chair
Health Equity & Quality Subcommittee
IL HFS Medicaid Advisory Committee