



Rep. Gregory Harris

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1 AMENDMENT TO SENATE BILL 1773

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 1773, AS AMENDED,  
3 by replacing everything after the enacting clause with the  
4 following:

5 "Section 1. Legislative intent. The General Assembly  
6 declares that is the legislative intent of the 100th General  
7 Assembly that, in order to best preserve and improve access to  
8 hospital services for Illinois Medicaid beneficiaries, the  
9 assessment imposed and payments required under this Act are to  
10 be presented to the federal Centers for Medicare and Medicaid  
11 Services as a 6-year program.

12 In accordance with guidelines promulgated by the federal  
13 Centers for Medicare and Medicaid Services, the assessment plan  
14 presented shall phase in claims-based payments through  
15 increasing amounts over 6 years. The Department of Healthcare  
16 and Family Services, in consultation with the Hospital  
17 Transformation Review Committee, the hospital community, and

1 the managed care organizations contracting with the State to  
2 provide medicaid services, shall evaluate the State fiscal year  
3 claims-based payments to monitor whether the proposed rates and  
4 methodologies resulted in expected reimbursement estimates,  
5 taking into consideration any changes in utilization patterns.

6 Section 2. The Illinois Administrative Procedure Act is  
7 amended by changing Section 5-45 and by adding Section 5-46.3  
8 as follows:

9 (5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

10 Sec. 5-45. Emergency rulemaking.

11 (a) "Emergency" means the existence of any situation that  
12 any agency finds reasonably constitutes a threat to the public  
13 interest, safety, or welfare.

14 (b) If any agency finds that an emergency exists that  
15 requires adoption of a rule upon fewer days than is required by  
16 Section 5-40 and states in writing its reasons for that  
17 finding, the agency may adopt an emergency rule without prior  
18 notice or hearing upon filing a notice of emergency rulemaking  
19 with the Secretary of State under Section 5-70. The notice  
20 shall include the text of the emergency rule and shall be  
21 published in the Illinois Register. Consent orders or other  
22 court orders adopting settlements negotiated by an agency may  
23 be adopted under this Section. Subject to applicable  
24 constitutional or statutory provisions, an emergency rule

1 becomes effective immediately upon filing under Section 5-65 or  
2 at a stated date less than 10 days thereafter. The agency's  
3 finding and a statement of the specific reasons for the finding  
4 shall be filed with the rule. The agency shall take reasonable  
5 and appropriate measures to make emergency rules known to the  
6 persons who may be affected by them.

7 (c) An emergency rule may be effective for a period of not  
8 longer than 150 days, but the agency's authority to adopt an  
9 identical rule under Section 5-40 is not precluded. No  
10 emergency rule may be adopted more than once in any 24-month  
11 period, except that this limitation on the number of emergency  
12 rules that may be adopted in a 24-month period does not apply  
13 to (i) emergency rules that make additions to and deletions  
14 from the Drug Manual under Section 5-5.16 of the Illinois  
15 Public Aid Code or the generic drug formulary under Section  
16 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii)  
17 emergency rules adopted by the Pollution Control Board before  
18 July 1, 1997 to implement portions of the Livestock Management  
19 Facilities Act, (iii) emergency rules adopted by the Illinois  
20 Department of Public Health under subsections (a) through (i)  
21 of Section 2 of the Department of Public Health Act when  
22 necessary to protect the public's health, (iv) emergency rules  
23 adopted pursuant to subsection (n) of this Section, (v)  
24 emergency rules adopted pursuant to subsection (o) of this  
25 Section, or (vi) emergency rules adopted pursuant to subsection  
26 (c-5) of this Section. Two or more emergency rules having

1 substantially the same purpose and effect shall be deemed to be  
2 a single rule for purposes of this Section.

3 (c-5) To facilitate the maintenance of the program of group  
4 health benefits provided to annuitants, survivors, and retired  
5 employees under the State Employees Group Insurance Act of  
6 1971, rules to alter the contributions to be paid by the State,  
7 annuitants, survivors, retired employees, or any combination  
8 of those entities, for that program of group health benefits,  
9 shall be adopted as emergency rules. The adoption of those  
10 rules shall be considered an emergency and necessary for the  
11 public interest, safety, and welfare.

12 (d) In order to provide for the expeditious and timely  
13 implementation of the State's fiscal year 1999 budget,  
14 emergency rules to implement any provision of Public Act 90-587  
15 or 90-588 or any other budget initiative for fiscal year 1999  
16 may be adopted in accordance with this Section by the agency  
17 charged with administering that provision or initiative,  
18 except that the 24-month limitation on the adoption of  
19 emergency rules and the provisions of Sections 5-115 and 5-125  
20 do not apply to rules adopted under this subsection (d). The  
21 adoption of emergency rules authorized by this subsection (d)  
22 shall be deemed to be necessary for the public interest,  
23 safety, and welfare.

24 (e) In order to provide for the expeditious and timely  
25 implementation of the State's fiscal year 2000 budget,  
26 emergency rules to implement any provision of Public Act 91-24

1 or any other budget initiative for fiscal year 2000 may be  
2 adopted in accordance with this Section by the agency charged  
3 with administering that provision or initiative, except that  
4 the 24-month limitation on the adoption of emergency rules and  
5 the provisions of Sections 5-115 and 5-125 do not apply to  
6 rules adopted under this subsection (e). The adoption of  
7 emergency rules authorized by this subsection (e) shall be  
8 deemed to be necessary for the public interest, safety, and  
9 welfare.

10 (f) In order to provide for the expeditious and timely  
11 implementation of the State's fiscal year 2001 budget,  
12 emergency rules to implement any provision of Public Act 91-712  
13 or any other budget initiative for fiscal year 2001 may be  
14 adopted in accordance with this Section by the agency charged  
15 with administering that provision or initiative, except that  
16 the 24-month limitation on the adoption of emergency rules and  
17 the provisions of Sections 5-115 and 5-125 do not apply to  
18 rules adopted under this subsection (f). The adoption of  
19 emergency rules authorized by this subsection (f) shall be  
20 deemed to be necessary for the public interest, safety, and  
21 welfare.

22 (g) In order to provide for the expeditious and timely  
23 implementation of the State's fiscal year 2002 budget,  
24 emergency rules to implement any provision of Public Act 92-10  
25 or any other budget initiative for fiscal year 2002 may be  
26 adopted in accordance with this Section by the agency charged

1 with administering that provision or initiative, except that  
2 the 24-month limitation on the adoption of emergency rules and  
3 the provisions of Sections 5-115 and 5-125 do not apply to  
4 rules adopted under this subsection (g). The adoption of  
5 emergency rules authorized by this subsection (g) shall be  
6 deemed to be necessary for the public interest, safety, and  
7 welfare.

8 (h) In order to provide for the expeditious and timely  
9 implementation of the State's fiscal year 2003 budget,  
10 emergency rules to implement any provision of Public Act 92-597  
11 or any other budget initiative for fiscal year 2003 may be  
12 adopted in accordance with this Section by the agency charged  
13 with administering that provision or initiative, except that  
14 the 24-month limitation on the adoption of emergency rules and  
15 the provisions of Sections 5-115 and 5-125 do not apply to  
16 rules adopted under this subsection (h). The adoption of  
17 emergency rules authorized by this subsection (h) shall be  
18 deemed to be necessary for the public interest, safety, and  
19 welfare.

20 (i) In order to provide for the expeditious and timely  
21 implementation of the State's fiscal year 2004 budget,  
22 emergency rules to implement any provision of Public Act 93-20  
23 or any other budget initiative for fiscal year 2004 may be  
24 adopted in accordance with this Section by the agency charged  
25 with administering that provision or initiative, except that  
26 the 24-month limitation on the adoption of emergency rules and

1 the provisions of Sections 5-115 and 5-125 do not apply to  
2 rules adopted under this subsection (i). The adoption of  
3 emergency rules authorized by this subsection (i) shall be  
4 deemed to be necessary for the public interest, safety, and  
5 welfare.

6 (j) In order to provide for the expeditious and timely  
7 implementation of the provisions of the State's fiscal year  
8 2005 budget as provided under the Fiscal Year 2005 Budget  
9 Implementation (Human Services) Act, emergency rules to  
10 implement any provision of the Fiscal Year 2005 Budget  
11 Implementation (Human Services) Act may be adopted in  
12 accordance with this Section by the agency charged with  
13 administering that provision, except that the 24-month  
14 limitation on the adoption of emergency rules and the  
15 provisions of Sections 5-115 and 5-125 do not apply to rules  
16 adopted under this subsection (j). The Department of Public Aid  
17 may also adopt rules under this subsection (j) necessary to  
18 administer the Illinois Public Aid Code and the Children's  
19 Health Insurance Program Act. The adoption of emergency rules  
20 authorized by this subsection (j) shall be deemed to be  
21 necessary for the public interest, safety, and welfare.

22 (k) In order to provide for the expeditious and timely  
23 implementation of the provisions of the State's fiscal year  
24 2006 budget, emergency rules to implement any provision of  
25 Public Act 94-48 or any other budget initiative for fiscal year  
26 2006 may be adopted in accordance with this Section by the

1 agency charged with administering that provision or  
2 initiative, except that the 24-month limitation on the adoption  
3 of emergency rules and the provisions of Sections 5-115 and  
4 5-125 do not apply to rules adopted under this subsection (k).  
5 The Department of Healthcare and Family Services may also adopt  
6 rules under this subsection (k) necessary to administer the  
7 Illinois Public Aid Code, the Senior Citizens and Persons with  
8 Disabilities Property Tax Relief Act, the Senior Citizens and  
9 Disabled Persons Prescription Drug Discount Program Act (now  
10 the Illinois Prescription Drug Discount Program Act), and the  
11 Children's Health Insurance Program Act. The adoption of  
12 emergency rules authorized by this subsection (k) shall be  
13 deemed to be necessary for the public interest, safety, and  
14 welfare.

15 (l) In order to provide for the expeditious and timely  
16 implementation of the provisions of the State's fiscal year  
17 2007 budget, the Department of Healthcare and Family Services  
18 may adopt emergency rules during fiscal year 2007, including  
19 rules effective July 1, 2007, in accordance with this  
20 subsection to the extent necessary to administer the  
21 Department's responsibilities with respect to amendments to  
22 the State plans and Illinois waivers approved by the federal  
23 Centers for Medicare and Medicaid Services necessitated by the  
24 requirements of Title XIX and Title XXI of the federal Social  
25 Security Act. The adoption of emergency rules authorized by  
26 this subsection (l) shall be deemed to be necessary for the



1 public interest, safety, and welfare.

2 (m) In order to provide for the expeditious and timely  
3 implementation of the provisions of the State's fiscal year  
4 2008 budget, the Department of Healthcare and Family Services  
5 may adopt emergency rules during fiscal year 2008, including  
6 rules effective July 1, 2008, in accordance with this  
7 subsection to the extent necessary to administer the  
8 Department's responsibilities with respect to amendments to  
9 the State plans and Illinois waivers approved by the federal  
10 Centers for Medicare and Medicaid Services necessitated by the  
11 requirements of Title XIX and Title XXI of the federal Social  
12 Security Act. The adoption of emergency rules authorized by  
13 this subsection (m) shall be deemed to be necessary for the  
14 public interest, safety, and welfare.

15 (n) In order to provide for the expeditious and timely  
16 implementation of the provisions of the State's fiscal year  
17 2010 budget, emergency rules to implement any provision of  
18 Public Act 96-45 or any other budget initiative authorized by  
19 the 96th General Assembly for fiscal year 2010 may be adopted  
20 in accordance with this Section by the agency charged with  
21 administering that provision or initiative. The adoption of  
22 emergency rules authorized by this subsection (n) shall be  
23 deemed to be necessary for the public interest, safety, and  
24 welfare. The rulemaking authority granted in this subsection  
25 (n) shall apply only to rules promulgated during Fiscal Year  
26 2010.

1           (o) In order to provide for the expeditious and timely  
2 implementation of the provisions of the State's fiscal year  
3 2011 budget, emergency rules to implement any provision of  
4 Public Act 96-958 or any other budget initiative authorized by  
5 the 96th General Assembly for fiscal year 2011 may be adopted  
6 in accordance with this Section by the agency charged with  
7 administering that provision or initiative. The adoption of  
8 emergency rules authorized by this subsection (o) is deemed to  
9 be necessary for the public interest, safety, and welfare. The  
10 rulemaking authority granted in this subsection (o) applies  
11 only to rules promulgated on or after July 1, 2010 (the  
12 effective date of Public Act 96-958) through June 30, 2011.

13           (p) In order to provide for the expeditious and timely  
14 implementation of the provisions of Public Act 97-689,  
15 emergency rules to implement any provision of Public Act 97-689  
16 may be adopted in accordance with this subsection (p) by the  
17 agency charged with administering that provision or  
18 initiative. The 150-day limitation of the effective period of  
19 emergency rules does not apply to rules adopted under this  
20 subsection (p), and the effective period may continue through  
21 June 30, 2013. The 24-month limitation on the adoption of  
22 emergency rules does not apply to rules adopted under this  
23 subsection (p). The adoption of emergency rules authorized by  
24 this subsection (p) is deemed to be necessary for the public  
25 interest, safety, and welfare.

26           (q) In order to provide for the expeditious and timely

1 implementation of the provisions of Articles 7, 8, 9, 11, and  
2 12 of Public Act 98-104, emergency rules to implement any  
3 provision of Articles 7, 8, 9, 11, and 12 of Public Act 98-104  
4 may be adopted in accordance with this subsection (q) by the  
5 agency charged with administering that provision or  
6 initiative. The 24-month limitation on the adoption of  
7 emergency rules does not apply to rules adopted under this  
8 subsection (q). The adoption of emergency rules authorized by  
9 this subsection (q) is deemed to be necessary for the public  
10 interest, safety, and welfare.

11 (r) In order to provide for the expeditious and timely  
12 implementation of the provisions of Public Act 98-651,  
13 emergency rules to implement Public Act 98-651 may be adopted  
14 in accordance with this subsection (r) by the Department of  
15 Healthcare and Family Services. The 24-month limitation on the  
16 adoption of emergency rules does not apply to rules adopted  
17 under this subsection (r). The adoption of emergency rules  
18 authorized by this subsection (r) is deemed to be necessary for  
19 the public interest, safety, and welfare.

20 (s) In order to provide for the expeditious and timely  
21 implementation of the provisions of Sections 5-5b.1 and 5A-2 of  
22 the Illinois Public Aid Code, emergency rules to implement any  
23 provision of Section 5-5b.1 or Section 5A-2 of the Illinois  
24 Public Aid Code may be adopted in accordance with this  
25 subsection (s) by the Department of Healthcare and Family  
26 Services. The rulemaking authority granted in this subsection

1 (s) shall apply only to those rules adopted prior to July 1,  
2 2015. Notwithstanding any other provision of this Section, any  
3 emergency rule adopted under this subsection (s) shall only  
4 apply to payments made for State fiscal year 2015. The adoption  
5 of emergency rules authorized by this subsection (s) is deemed  
6 to be necessary for the public interest, safety, and welfare.

7 (t) In order to provide for the expeditious and timely  
8 implementation of the provisions of Article II of Public Act  
9 99-6, emergency rules to implement the changes made by Article  
10 II of Public Act 99-6 to the Emergency Telephone System Act may  
11 be adopted in accordance with this subsection (t) by the  
12 Department of State Police. The rulemaking authority granted in  
13 this subsection (t) shall apply only to those rules adopted  
14 prior to July 1, 2016. The 24-month limitation on the adoption  
15 of emergency rules does not apply to rules adopted under this  
16 subsection (t). The adoption of emergency rules authorized by  
17 this subsection (t) is deemed to be necessary for the public  
18 interest, safety, and welfare.

19 (u) In order to provide for the expeditious and timely  
20 implementation of the provisions of the Burn Victims Relief  
21 Act, emergency rules to implement any provision of the Act may  
22 be adopted in accordance with this subsection (u) by the  
23 Department of Insurance. The rulemaking authority granted in  
24 this subsection (u) shall apply only to those rules adopted  
25 prior to December 31, 2015. The adoption of emergency rules  
26 authorized by this subsection (u) is deemed to be necessary for

1 the public interest, safety, and welfare.

2 (v) In order to provide for the expeditious and timely  
3 implementation of the provisions of Public Act 99-516,  
4 emergency rules to implement Public Act 99-516 may be adopted  
5 in accordance with this subsection (v) by the Department of  
6 Healthcare and Family Services. The 24-month limitation on the  
7 adoption of emergency rules does not apply to rules adopted  
8 under this subsection (v). The adoption of emergency rules  
9 authorized by this subsection (v) is deemed to be necessary for  
10 the public interest, safety, and welfare.

11 (w) In order to provide for the expeditious and timely  
12 implementation of the provisions of Public Act 99-796,  
13 emergency rules to implement the changes made by Public Act  
14 99-796 may be adopted in accordance with this subsection (w) by  
15 the Adjutant General. The adoption of emergency rules  
16 authorized by this subsection (w) is deemed to be necessary for  
17 the public interest, safety, and welfare.

18 (x) In order to provide for the expeditious and timely  
19 implementation of the provisions of Public Act 99-906,  
20 emergency rules to implement subsection (i) of Section 16-115D,  
21 subsection (g) of Section 16-128A, and subsection (a) of  
22 Section 16-128B of the Public Utilities Act may be adopted in  
23 accordance with this subsection (x) by the Illinois Commerce  
24 Commission. The rulemaking authority granted in this  
25 subsection (x) shall apply only to those rules adopted within  
26 180 days after June 1, 2017 (the effective date of Public Act

1 99-906). The adoption of emergency rules authorized by this  
2 subsection (x) is deemed to be necessary for the public  
3 interest, safety, and welfare.

4 (y) In order to provide for the expeditious and timely  
5 implementation of the provisions of this amendatory Act of the  
6 100th General Assembly, emergency rules to implement the  
7 changes made by this amendatory Act of the 100th General  
8 Assembly to Section 4.02 of the Illinois Act on Aging, Sections  
9 5.5.4 and 5-5.4i of the Illinois Public Aid Code, Section 55-30  
10 of the Alcoholism and Other Drug Abuse and Dependency Act, and  
11 Sections 74 and 75 of the Mental Health and Developmental  
12 Disabilities Administrative Act may be adopted in accordance  
13 with this subsection (y) by the respective Department. The  
14 adoption of emergency rules authorized by this subsection (y)  
15 is deemed to be necessary for the public interest, safety, and  
16 welfare.

17 (z) In order to provide for the expeditious and timely  
18 implementation of the provisions of this amendatory Act of the  
19 100th General Assembly, emergency rules to implement the  
20 changes made by this amendatory Act of the 100th General  
21 Assembly to Section 4.7 of the Lobbyist Registration Act may be  
22 adopted in accordance with this subsection (z) by the Secretary  
23 of State. The adoption of emergency rules authorized by this  
24 subsection (z) is deemed to be necessary for the public  
25 interest, safety, and welfare.

26 (aa) In order to provide for the expeditious and timely

1 initial implementation of the changes made to Articles 5, 5A,  
2 12, and 14 of the Illinois Public Aid Code under the provisions  
3 of this amendatory Act of the 100th General Assembly, the  
4 Department of Healthcare and Family Services may adopt  
5 emergency rules in accordance with this subsection (aa). The  
6 24-month limitation on the adoption of emergency rules does not  
7 apply to rules to initially implement the changes made to  
8 Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code  
9 adopted under this subsection (aa). The adoption of emergency  
10 rules authorized by this subsection (aa) is deemed to be  
11 necessary for the public interest, safety, and welfare.

12 (Source: P.A. 99-2, eff. 3-26-15; 99-6, eff. 1-1-16; 99-143,  
13 eff. 7-27-15; 99-455, eff. 1-1-16; 99-516, eff. 6-30-16;  
14 99-642, eff. 7-28-16; 99-796, eff. 1-1-17; 99-906, eff. 6-1-17;  
15 100-23, eff. 7-6-17; 100-554, eff. 11-16-17.)

16 (5 ILCS 100/5-46.3 new)

17 Sec. 5-46.3. Approval of rules to implement the hospital  
18 transformation program. Notwithstanding any other provision of  
19 this Act, the Department of Healthcare and Family Services may  
20 not file, the Secretary of State may not accept, and the Joint  
21 Committee on Administrative Rules may not consider any rules  
22 adopted in accordance to subsection (d-5) of Section 14-12 of  
23 the Illinois Public Aid Code unless the rules have been  
24 approved by 9 of the 14 members of the Hospital Transformation  
25 Review Committee created under subsection (d-5) of Section

1 14-12 of the Illinois Public Aid Code. Approval of the rules  
2 shall be demonstrated by submission of a written document  
3 signed by each of the 9 approving members. The Department of  
4 Healthcare and Family Services shall submit the written  
5 document with signatures, along with a certified copy of each  
6 rule, to the Secretary of State.

7 Section 3. The Illinois Health Facilities Planning Act is  
8 amended by changing Section 3 as follows:

9 (20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

10 (Text of Section before amendment by P.A. 100-518)

11 (Section scheduled to be repealed on December 31, 2019)

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

13 "Health care facilities" means and includes the following  
14 facilities, organizations, and related persons:

15 (1) An ambulatory surgical treatment center required  
16 to be licensed pursuant to the Ambulatory Surgical  
17 Treatment Center Act.

18 (2) An institution, place, building, or agency  
19 required to be licensed pursuant to the Hospital Licensing  
20 Act.

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

23 (A) If a demonstration project under the Nursing  
24 Home Care Act applies for a certificate of need to



1 convert to a nursing facility, it shall meet the  
2 licensure and certificate of need requirements in  
3 effect as of the date of application.

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

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

20 (3.7) Facilities licensed under the Specialized Mental  
21 Health Rehabilitation Act of 2013.

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

26 (5) Kidney disease treatment centers, including a

1 free-standing hemodialysis unit required to be licensed  
2 under the End Stage Renal Disease Facility 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) Any project the Department of Healthcare and Family  
24 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 (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 "Non-clinical service area" means an area (i) for the  
11 benefit of the patients, visitors, staff, or employees of a  
12 health care facility and (ii) not directly related to the  
13 diagnosis, treatment, or rehabilitation of persons receiving  
14 services from the health care facility. "Non-clinical service  
15 areas" include, but are not limited to, chapels; gift shops;  
16 news stands; computer systems; tunnels, walkways, and  
17 elevators; telephone systems; projects to comply with life  
18 safety codes; educational facilities; student housing;  
19 patient, employee, staff, and visitor dining areas;  
20 administration and volunteer offices; modernization of  
21 structural components (such as roof replacement and masonry  
22 work); boiler repair or replacement; vehicle maintenance and  
23 storage facilities; parking facilities; mechanical systems for  
24 heating, ventilation, and air conditioning; loading docks; and  
25 repair or replacement of carpeting, tile, wall coverings,  
26 window coverings or treatments, or furniture. Solely for the

1 purpose of this definition, "non-clinical service area" does  
2 not include health and fitness centers.

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

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

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

15 "Licensed health care professional" means a person  
16 licensed to practice a health profession under pertinent  
17 licensing statutes of the State of Illinois.

18 "Director" means the Director of the Illinois Department of  
19 Public Health.

20 "Agency" or "Department" means the Illinois Department of  
21 Public Health.

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

24 "Out-of-state facility" means a person that is both (i)  
25 licensed as a hospital or as an ambulatory surgery center under  
26 the laws of another state or that qualifies as a hospital or an

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

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

21 "Related person" means any person that: (i) is at least 50%  
22 owned, directly or indirectly, by either the health care  
23 facility or a person owning, directly or indirectly, at least  
24 50% of the health care facility; or (ii) owns, directly or  
25 indirectly, at least 50% of the health care facility.

26 "Charity care" means care provided by a health care

1 facility for which the provider does not expect to receive  
2 payment from the patient or a third-party payer.

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

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

19 "State Board Staff Report" means the document that sets  
20 forth the review and findings of the State Board staff, as  
21 prescribed by the State Board, regarding applications subject  
22 to Board jurisdiction.

23 (Source: P.A. 98-414, eff. 1-1-14; 98-629, eff. 1-1-15; 98-651,  
24 eff. 6-16-14; 98-1086, eff. 8-26-14; 99-78, eff. 7-20-15;  
25 99-180, eff. 7-29-15; 99-527, eff. 1-1-17.)

1 (Text of Section after amendment by P.A. 100-518)

2 (Section scheduled to be repealed on December 31, 2019)

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

4 "Health care facilities" means and includes the following  
5 facilities, organizations, and related persons:

6 (1) An ambulatory surgical treatment center required  
7 to be licensed pursuant to the Ambulatory Surgical  
8 Treatment Center Act.

9 (2) An institution, place, building, or agency  
10 required to be licensed pursuant to the Hospital Licensing  
11 Act.

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

14 (A) If a demonstration project under the Nursing  
15 Home Care Act applies for a certificate of need to  
16 convert to a nursing facility, it shall meet the  
17 licensure and certificate of need requirements in  
18 effect as of the date of application.

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

23 (3.5) Skilled and intermediate care facilities  
24 licensed under the ID/DD Community Care Act or the MC/DD  
25 Act. No permit or exemption is required for a facility  
26 licensed under the ID/DD Community Care Act or the MC/DD

1 Act prior to the reduction of the number of beds at a  
2 facility. If there is a total reduction of beds at a  
3 facility licensed under the ID/DD Community Care Act or the  
4 MC/DD Act, this is a discontinuation or closure of the  
5 facility. If a facility licensed under the ID/DD Community  
6 Care Act or the MC/DD Act reduces the number of beds or  
7 discontinues the facility, that facility must notify the  
8 Board as provided in Section 14.1 of this Act.

9 (3.7) Facilities licensed under the Specialized Mental  
10 Health Rehabilitation Act of 2013.

11 (4) Hospitals, nursing homes, ambulatory surgical  
12 treatment centers, or kidney disease treatment centers  
13 maintained by the State or any department or agency  
14 thereof.

15 (5) Kidney disease treatment centers, including a  
16 free-standing hemodialysis unit required to be licensed  
17 under the End Stage Renal Disease Facility Act.

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

22 (B) This Act does not apply to a dialysis unit  
23 located in a licensed nursing home that offers or  
24 provides dialysis-related services to residents with  
25 end stage renal disease who have elected to receive  
26 home dialysis within the nursing home.

1 (C) The Board, however, may require dialysis  
2 facilities and licensed nursing homes under items (A)  
3 and (B) of this subsection to report statistical  
4 information on a quarterly basis to the Board to be  
5 used by the Board to conduct analyses on the need for  
6 proposed kidney disease treatment centers.

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

11 (7) An institution, place, building, or room used for  
12 provision of a health care category of service, including,  
13 but not limited to, cardiac catheterization and open heart  
14 surgery.

15 (8) An institution, place, building, or room housing  
16 major medical equipment used in the direct clinical  
17 diagnosis or treatment of patients, and whose project cost  
18 is in excess of the capital expenditure minimum.

19 "Health care facilities" does not include the following  
20 entities or facility transactions:

21 (1) Federally-owned facilities.

22 (2) Facilities used solely for healing by prayer or  
23 spiritual means.

24 (3) An existing facility located on any campus facility  
25 as defined in Section 5-5.8b of the Illinois Public Aid  
26 Code, provided that the campus facility encompasses 30 or

1 more contiguous acres and that the new or renovated  
2 facility is intended for use by a licensed residential  
3 facility.

4 (4) Facilities licensed under the Supportive  
5 Residences Licensing Act or the Assisted Living and Shared  
6 Housing Act.

7 (5) Facilities designated as supportive living  
8 facilities that are in good standing with the program  
9 established under Section 5-5.01a of the Illinois Public  
10 Aid Code.

11 (6) Facilities established and operating under the  
12 Alternative Health Care Delivery Act as a children's  
13 community-based health care center alternative health care  
14 model demonstration program or as an Alzheimer's Disease  
15 Management Center alternative health care model  
16 demonstration program.

17 (7) The closure of an entity or a portion of an entity  
18 licensed under the Nursing Home Care Act, the Specialized  
19 Mental Health Rehabilitation Act of 2013, the ID/DD  
20 Community Care Act, or the MC/DD Act, with the exception of  
21 facilities operated by a county or Illinois Veterans Homes,  
22 that elect to convert, in whole or in part, to an assisted  
23 living or shared housing establishment licensed under the  
24 Assisted Living and Shared Housing Act and with the  
25 exception of a facility licensed under the Specialized  
26 Mental Health Rehabilitation Act of 2013 in connection with



1 a proposal to close a facility and re-establish the  
2 facility in another location.

3 (8) Any change of ownership of a health care facility  
4 that is licensed under the Nursing Home Care Act, the  
5 Specialized Mental Health Rehabilitation Act of 2013, the  
6 ID/DD Community Care Act, or the MC/DD Act, with the  
7 exception of facilities operated by a county or Illinois  
8 Veterans Homes. Changes of ownership of facilities  
9 licensed under the Nursing Home Care Act must meet the  
10 requirements set forth in Sections 3-101 through 3-119 of  
11 the Nursing Home Care Act.

12 (9) Any project the Department of Healthcare and Family  
13 Services certifies was approved by the Hospital  
14 Transformation Review Committee as a project subject to the  
15 hospital's transformation under subsection (d-5) of  
16 Section 14-12 of the Illinois Public Aid Code, provided the  
17 hospital shall submit the certification to the Board.  
18 Nothing in this paragraph excludes a health care facility  
19 from the requirements of this Act after the approved  
20 transformation project is complete. All other requirements  
21 under this Act continue to apply. Hospitals that are not  
22 subject to this Act under this paragraph shall notify the  
23 Health Facilities and Services Review Board within 30 days  
24 of the dates that bed changes or service changes occur.

25 With the exception of those health care facilities  
26 specifically included in this Section, nothing in this Act

1 shall be intended to include facilities operated as a part of  
2 the practice of a physician or other licensed health care  
3 professional, whether practicing in his individual capacity or  
4 within the legal structure of any partnership, medical or  
5 professional corporation, or unincorporated medical or  
6 professional group. Further, this Act shall not apply to  
7 physicians or other licensed health care professional's  
8 practices where such practices are carried out in a portion of  
9 a health care facility under contract with such health care  
10 facility by a physician or by other licensed health care  
11 professionals, whether practicing in his individual capacity  
12 or within the legal structure of any partnership, medical or  
13 professional corporation, or unincorporated medical or  
14 professional groups, unless the entity constructs, modifies,  
15 or establishes a health care facility as specifically defined  
16 in this Section. This Act shall apply to construction or  
17 modification and to establishment by such health care facility  
18 of such contracted portion which is subject to facility  
19 licensing requirements, irrespective of the party responsible  
20 for such action or attendant financial obligation.

21 "Person" means any one or more natural persons, legal  
22 entities, governmental bodies other than federal, or any  
23 combination thereof.

24 "Consumer" means any person other than a person (a) whose  
25 major occupation currently involves or whose official capacity  
26 within the last 12 months has involved the providing,

1 administering or financing of any type of health care facility,  
2 (b) who is engaged in health research or the teaching of  
3 health, (c) who has a material financial interest in any  
4 activity which involves the providing, administering or  
5 financing of any type of health care facility, or (d) who is or  
6 ever has been a member of the immediate family of the person  
7 defined by (a), (b), or (c).

8 "State Board" or "Board" means the Health Facilities and  
9 Services Review Board.

10 "Construction or modification" means the establishment,  
11 erection, building, alteration, reconstruction, modernization,  
12 improvement, extension, discontinuation, change of ownership,  
13 of or by a health care facility, or the purchase or acquisition  
14 by or through a health care facility of equipment or service  
15 for diagnostic or therapeutic purposes or for facility  
16 administration or operation, or any capital expenditure made by  
17 or on behalf of a health care facility which exceeds the  
18 capital expenditure minimum; however, any capital expenditure  
19 made by or on behalf of a health care facility for (i) the  
20 construction or modification of a facility licensed under the  
21 Assisted Living and Shared Housing Act or (ii) a conversion  
22 project undertaken in accordance with Section 30 of the Older  
23 Adult Services Act shall be excluded from any obligations under  
24 this Act.

25 "Establish" means the construction of a health care  
26 facility or the replacement of an existing facility on another

1 site or the initiation of a category of service.

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

16 "Capital Expenditure" means an expenditure: (A) made by or  
17 on behalf of a health care facility (as such a facility is  
18 defined in this Act); and (B) which under generally accepted  
19 accounting principles is not properly chargeable as an expense  
20 of operation and maintenance, or is made to obtain by lease or  
21 comparable arrangement any facility or part thereof or any  
22 equipment for a facility or part; and which exceeds the capital  
23 expenditure minimum.

24 For the purpose of this paragraph, the cost of any studies,  
25 surveys, designs, plans, working drawings, specifications, and  
26 other activities essential to the acquisition, improvement,

1 expansion, or replacement of any plant or equipment with  
2 respect to which an expenditure is made shall be included in  
3 determining if such expenditure exceeds the capital  
4 expenditures minimum. Unless otherwise interdependent, or  
5 submitted as one project by the applicant, components of  
6 construction or modification undertaken by means of a single  
7 construction contract or financed through the issuance of a  
8 single debt instrument shall not be grouped together as one  
9 project. Donations of equipment or facilities to a health care  
10 facility which if acquired directly by such facility would be  
11 subject to review under this Act shall be considered capital  
12 expenditures, and a transfer of equipment or facilities for  
13 less than fair market value shall be considered a capital  
14 expenditure for purposes of this Act if a transfer of the  
15 equipment or facilities at fair market value would be subject  
16 to review.

17 "Capital expenditure minimum" means \$11,500,000 for  
18 projects by hospital applicants, \$6,500,000 for applicants for  
19 projects related to skilled and intermediate care long-term  
20 care facilities licensed under the Nursing Home Care Act, and  
21 \$3,000,000 for projects by all other applicants, which shall be  
22 annually adjusted to reflect the increase in construction costs  
23 due to inflation, for major medical equipment and for all other  
24 capital expenditures.

25 "Financial Commitment" means the commitment of at least 33%  
26 of total funds assigned to cover total project cost, which

1 occurs by the actual expenditure of 33% or more of the total  
2 project cost or the commitment to expend 33% or more of the  
3 total project cost by signed contracts or other legal means.

4 "Non-clinical service area" means an area (i) for the  
5 benefit of the patients, visitors, staff, or employees of a  
6 health care facility and (ii) not directly related to the  
7 diagnosis, treatment, or rehabilitation of persons receiving  
8 services from the health care facility. "Non-clinical service  
9 areas" include, but are not limited to, chapels; gift shops;  
10 news stands; computer systems; tunnels, walkways, and  
11 elevators; telephone systems; projects to comply with life  
12 safety codes; educational facilities; student housing;  
13 patient, employee, staff, and visitor dining areas;  
14 administration and volunteer offices; modernization of  
15 structural components (such as roof replacement and masonry  
16 work); boiler repair or replacement; vehicle maintenance and  
17 storage facilities; parking facilities; mechanical systems for  
18 heating, ventilation, and air conditioning; loading docks; and  
19 repair or replacement of carpeting, tile, wall coverings,  
20 window coverings or treatments, or furniture. Solely for the  
21 purpose of this definition, "non-clinical service area" does  
22 not include health and fitness centers.

23 "Areawide" means a major area of the State delineated on a  
24 geographic, demographic, and functional basis for health  
25 planning and for health service and having within it one or  
26 more local areas for health planning and health service. The

1 term "region", as contrasted with the term "subregion", and the  
2 word "area" may be used synonymously with the term "areawide".

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

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

9 "Licensed health care professional" means a person  
10 licensed to practice a health profession under pertinent  
11 licensing statutes of the State of Illinois.

12 "Director" means the Director of the Illinois Department of  
13 Public Health.

14 "Agency" or "Department" means the Illinois Department of  
15 Public Health.

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

18 "Out-of-state facility" means a person that is both (i)  
19 licensed as a hospital or as an ambulatory surgery center under  
20 the laws of another state or that qualifies as a hospital or an  
21 ambulatory surgery center under regulations adopted pursuant  
22 to the Social Security Act and (ii) not licensed under the  
23 Ambulatory Surgical Treatment Center Act, the Hospital  
24 Licensing Act, or the Nursing Home Care Act. Affiliates of  
25 out-of-state facilities shall be considered out-of-state  
26 facilities. Affiliates of Illinois licensed health care

1 facilities 100% owned by an Illinois licensed health care  
2 facility, its parent, or Illinois physicians licensed to  
3 practice medicine in all its branches shall not be considered  
4 out-of-state facilities. Nothing in this definition shall be  
5 construed to include an office or any part of an office of a  
6 physician licensed to practice medicine in all its branches in  
7 Illinois that is not required to be licensed under the  
8 Ambulatory Surgical Treatment Center Act.

9 "Change of ownership of a health care facility" means a  
10 change in the person who has ownership or control of a health  
11 care facility's physical plant and capital assets. A change in  
12 ownership is indicated by the following transactions: sale,  
13 transfer, acquisition, lease, change of sponsorship, or other  
14 means of transferring control.

15 "Related person" means any person that: (i) is at least 50%  
16 owned, directly or indirectly, by either the health care  
17 facility or a person owning, directly or indirectly, at least  
18 50% of the health care facility; or (ii) owns, directly or  
19 indirectly, at least 50% of the health care facility.

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

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

26 "Category of service" means a grouping by generic class of



1 various types or levels of support functions, equipment, care,  
2 or treatment provided to patients or residents, including, but  
3 not limited to, classes such as medical-surgical, pediatrics,  
4 or cardiac catheterization. A category of service may include  
5 subcategories or levels of care that identify a particular  
6 degree or type of care within the category of service. Nothing  
7 in this definition shall be construed to include the practice  
8 of a physician or other licensed health care professional while  
9 functioning in an office providing for the care, diagnosis, or  
10 treatment of patients. A category of service that is subject to  
11 the Board's jurisdiction must be designated in rules adopted by  
12 the Board.

13 "State Board Staff Report" means the document that sets  
14 forth the review and findings of the State Board staff, as  
15 prescribed by the State Board, regarding applications subject  
16 to Board jurisdiction.

17 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;  
18 99-527, eff. 1-1-17; 100-518, eff. 6-1-18.)

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

21 (210 ILCS 50/32.5)

22 Sec. 32.5. Freestanding Emergency Center.

23 (a) The Department shall issue an annual Freestanding  
24 Emergency Center (FEC) license to any facility that has

1 received a permit from the Health Facilities and Services  
2 Review Board to establish a Freestanding Emergency Center by  
3 January 1, 2015, and:

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

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

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

14 (A) facility design, specification, operation, and  
15 maintenance standards;

16 (B) equipment standards; and

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

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

1           (5) provides comprehensive emergency treatment  
2 services, as defined in the rules adopted by the Department  
3 pursuant to the Hospital Licensing Act, 24 hours per day,  
4 on an outpatient basis;

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

8           (7) (blank);

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

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

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

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

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

1 activities;

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

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

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

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

14 (17) pays the annual license fee as determined by the  
15 Department by rule.

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

25 (a-10) Notwithstanding any other provision of this  
26 Section, the Department may issue an annual FEC license to a

1 facility if the facility has, by January 1, 2014, filed a  
2 letter of intent to establish an FEC and if the facility  
3 complies with the requirements set forth in paragraphs (1)  
4 through (17) of subsection (a).

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

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

19 (1) the facility is a hospital that has discontinued  
20 inpatient hospital services;

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

26 (3) the facility complies with the requirements set

1       forth in paragraphs (1) through (17), provided however that  
2       the FEC may be located in a municipality with a population  
3       greater than 50,000 inhabitants and shall not be subject to  
4       the requirements of the Illinois Health Facilities  
5       Planning Act that are applicable to the conversion to an  
6       FEC if the Department of Healthcare and Family Service has  
7       certified the conversion to an FEC was approved by the  
8       Hospital Transformation Review Committee as a project  
9       subject to the hospital's transformation under subsection  
10       (d-5) of Section 14-12 of the Illinois Public Aid Code; and  
11       (4) the facility is located at the same physical  
12       location where the facility served as a hospital.

13       (b) The Department shall:

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

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

24           (3) issue an Emergency Suspension Order for any FEC  
25       when the Director or his or her designee has determined  
26       that the continued operation of the FEC poses an immediate

1 and serious danger to the public health, safety, and  
2 welfare. An opportunity for a hearing shall be promptly  
3 initiated after an Emergency Suspension Order has been  
4 issued; and

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

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

7 Section 15. The Illinois Public Aid Code is amended by  
8 changing Sections 5-5.02, 5-5e.1, 5A-2, 5A-4, 5A-5, 5A-8,  
9 5A-10, 5A-12.5, 5A-13, 5A-14, 5A-15, 12-4.105, and 14-12, and  
10 by adding Sections 5A-12.6, and 5A-16 as follows:

11 (305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

12 Sec. 5-5.02. Hospital reimbursements.

13 (a) Reimbursement to Hospitals; July 1, 1992 through  
14 September 30, 1992. Notwithstanding any other provisions of  
15 this Code or the Illinois Department's Rules promulgated under  
16 the Illinois Administrative Procedure Act, reimbursement to  
17 hospitals for services provided during the period July 1, 1992  
18 through September 30, 1992, shall be as follows:

19 (1) For inpatient hospital services rendered, or if  
20 applicable, for inpatient hospital discharges occurring,  
21 on or after July 1, 1992 and on or before September 30,  
22 1992, the Illinois Department shall reimburse hospitals  
23 for inpatient services under the reimbursement  
24 methodologies in effect for each hospital, and at the

1 inpatient payment rate calculated for each hospital, as of  
2 June 30, 1992. For purposes of this paragraph,  
3 "reimbursement methodologies" means all reimbursement  
4 methodologies that pertain to the provision of inpatient  
5 hospital services, including, but not limited to, any  
6 adjustments for disproportionate share, targeted access,  
7 critical care access and uncompensated care, as defined by  
8 the Illinois Department on June 30, 1992.

9 (2) For the purpose of calculating the inpatient  
10 payment rate for each hospital eligible to receive  
11 quarterly adjustment payments for targeted access and  
12 critical care, as defined by the Illinois Department on  
13 June 30, 1992, the adjustment payment for the period July  
14 1, 1992 through September 30, 1992, shall be 25% of the  
15 annual adjustment payments calculated for each eligible  
16 hospital, as of June 30, 1992. The Illinois Department  
17 shall determine by rule the adjustment payments for  
18 targeted access and critical care beginning October 1,  
19 1992.

20 (3) For the purpose of calculating the inpatient  
21 payment rate for each hospital eligible to receive  
22 quarterly adjustment payments for uncompensated care, as  
23 defined by the Illinois Department on June 30, 1992, the  
24 adjustment payment for the period August 1, 1992 through  
25 September 30, 1992, shall be one-sixth of the total  
26 uncompensated care adjustment payments calculated for each



1 eligible hospital for the uncompensated care rate year, as  
2 defined by the Illinois Department, ending on July 31,  
3 1992. The Illinois Department shall determine by rule the  
4 adjustment payments for uncompensated care beginning  
5 October 1, 1992.

6 (b) Inpatient payments. For inpatient services provided on  
7 or after October 1, 1993, in addition to rates paid for  
8 hospital inpatient services pursuant to the Illinois Health  
9 Finance Reform Act, as now or hereafter amended, or the  
10 Illinois Department's prospective reimbursement methodology,  
11 or any other methodology used by the Illinois Department for  
12 inpatient services, the Illinois Department shall make  
13 adjustment payments, in an amount calculated pursuant to the  
14 methodology described in paragraph (c) of this Section, to  
15 hospitals that the Illinois Department determines satisfy any  
16 one of the following requirements:

17 (1) Hospitals that are described in Section 1923 of the  
18 federal Social Security Act, as now or hereafter amended,  
19 except that for rate year 2015 and after a hospital  
20 described in Section 1923(b)(1)(B) of the federal Social  
21 Security Act and qualified for the payments described in  
22 subsection (c) of this Section for rate year 2014 provided  
23 the hospital continues to meet the description in Section  
24 1923(b)(1)(B) in the current determination year; or

25 (2) Illinois hospitals that have a Medicaid inpatient  
26 utilization rate which is at least one-half a standard

1 deviation above the mean Medicaid inpatient utilization  
2 rate for all hospitals in Illinois receiving Medicaid  
3 payments from the Illinois Department; or

4 (3) Illinois hospitals that on July 1, 1991 had a  
5 Medicaid inpatient utilization rate, as defined in  
6 paragraph (h) of this Section, that was at least the mean  
7 Medicaid inpatient utilization rate for all hospitals in  
8 Illinois receiving Medicaid payments from the Illinois  
9 Department and which were located in a planning area with  
10 one-third or fewer excess beds as determined by the Health  
11 Facilities and Services Review Board, and that, as of June  
12 30, 1992, were located in a federally designated Health  
13 Manpower Shortage Area; or

14 (4) Illinois hospitals that:

15 (A) have a Medicaid inpatient utilization rate  
16 that is at least equal to the mean Medicaid inpatient  
17 utilization rate for all hospitals in Illinois  
18 receiving Medicaid payments from the Department; and

19 (B) also have a Medicaid obstetrical inpatient  
20 utilization rate that is at least one standard  
21 deviation above the mean Medicaid obstetrical  
22 inpatient utilization rate for all hospitals in  
23 Illinois receiving Medicaid payments from the  
24 Department for obstetrical services; or

25 (5) Any children's hospital, which means a hospital  
26 devoted exclusively to caring for children. A hospital

1 which includes a facility devoted exclusively to caring for  
2 children shall be considered a children's hospital to the  
3 degree that the hospital's Medicaid care is provided to  
4 children if either (i) the facility devoted exclusively to  
5 caring for children is separately licensed as a hospital by  
6 a municipality prior to February 28, 2013 or (ii) the  
7 hospital has been designated by the State as a Level III  
8 perinatal care facility, has a Medicaid Inpatient  
9 Utilization rate greater than 55% for the rate year 2003  
10 disproportionate share determination, and has more than  
11 10,000 qualified children days as defined by the Department  
12 in rulemaking.

13 (c) Inpatient adjustment payments. The adjustment payments  
14 required by paragraph (b) shall be calculated based upon the  
15 hospital's Medicaid inpatient utilization rate as follows:

16 (1) hospitals with a Medicaid inpatient utilization  
17 rate below the mean shall receive a per day adjustment  
18 payment equal to \$25;

19 (2) hospitals with a Medicaid inpatient utilization  
20 rate that is equal to or greater than the mean Medicaid  
21 inpatient utilization rate but less than one standard  
22 deviation above the mean Medicaid inpatient utilization  
23 rate shall receive a per day adjustment payment equal to  
24 the sum of \$25 plus \$1 for each one percent that the  
25 hospital's Medicaid inpatient utilization rate exceeds the  
26 mean Medicaid inpatient utilization rate;

1           (3) hospitals with a Medicaid inpatient utilization  
2 rate that is equal to or greater than one standard  
3 deviation above the mean Medicaid inpatient utilization  
4 rate but less than 1.5 standard deviations above the mean  
5 Medicaid inpatient utilization rate shall receive a per day  
6 adjustment payment equal to the sum of \$40 plus \$7 for each  
7 one percent that the hospital's Medicaid inpatient  
8 utilization rate exceeds one standard deviation above the  
9 mean Medicaid inpatient utilization rate; and

10           (4) hospitals with a Medicaid inpatient utilization  
11 rate that is equal to or greater than 1.5 standard  
12 deviations above the mean Medicaid inpatient utilization  
13 rate shall receive a per day adjustment payment equal to  
14 the sum of \$90 plus \$2 for each one percent that the  
15 hospital's Medicaid inpatient utilization rate exceeds 1.5  
16 standard deviations above the mean Medicaid inpatient  
17 utilization rate.

18           (d) Supplemental adjustment payments. In addition to the  
19 adjustment payments described in paragraph (c), hospitals as  
20 defined in clauses (1) through (5) of paragraph (b), excluding  
21 county hospitals (as defined in subsection (c) of Section 15-1  
22 of this Code) and a hospital organized under the University of  
23 Illinois Hospital Act, shall be paid supplemental inpatient  
24 adjustment payments of \$60 per day. For purposes of Title XIX  
25 of the federal Social Security Act, these supplemental  
26 adjustment payments shall not be classified as adjustment

1 payments to disproportionate share hospitals.

2 (e) The inpatient adjustment payments described in  
3 paragraphs (c) and (d) shall be increased on October 1, 1993  
4 and annually thereafter by a percentage equal to the lesser of  
5 (i) the increase in the DRI hospital cost index for the most  
6 recent 12 month period for which data are available, or (ii)  
7 the percentage increase in the statewide average hospital  
8 payment rate over the previous year's statewide average  
9 hospital payment rate. The sum of the inpatient adjustment  
10 payments under paragraphs (c) and (d) to a hospital, other than  
11 a county hospital (as defined in subsection (c) of Section 15-1  
12 of this Code) or a hospital organized under the University of  
13 Illinois Hospital Act, however, shall not exceed \$275 per day;  
14 that limit shall be increased on October 1, 1993 and annually  
15 thereafter by a percentage equal to the lesser of (i) the  
16 increase in the DRI hospital cost index for the most recent  
17 12-month period for which data are available or (ii) the  
18 percentage increase in the statewide average hospital payment  
19 rate over the previous year's statewide average hospital  
20 payment rate.

21 (f) Children's hospital inpatient adjustment payments. For  
22 children's hospitals, as defined in clause (5) of paragraph  
23 (b), the adjustment payments required pursuant to paragraphs  
24 (c) and (d) shall be multiplied by 2.0.

25 (g) County hospital inpatient adjustment payments. For  
26 county hospitals, as defined in subsection (c) of Section 15-1

1 of this Code, there shall be an adjustment payment as  
2 determined by rules issued by the Illinois Department.

3 (h) For the purposes of this Section the following terms  
4 shall be defined as follows:

5 (1) "Medicaid inpatient utilization rate" means a  
6 fraction, the numerator of which is the number of a  
7 hospital's inpatient days provided in a given 12-month  
8 period to patients who, for such days, were eligible for  
9 Medicaid under Title XIX of the federal Social Security  
10 Act, and the denominator of which is the total number of  
11 the hospital's inpatient days in that same period.

12 (2) "Mean Medicaid inpatient utilization rate" means  
13 the total number of Medicaid inpatient days provided by all  
14 Illinois Medicaid-participating hospitals divided by the  
15 total number of inpatient days provided by those same  
16 hospitals.

17 (3) "Medicaid obstetrical inpatient utilization rate"  
18 means the ratio of Medicaid obstetrical inpatient days to  
19 total Medicaid inpatient days for all Illinois hospitals  
20 receiving Medicaid payments from the Illinois Department.

21 (i) Inpatient adjustment payment limit. In order to meet  
22 the limits of Public Law 102-234 and Public Law 103-66, the  
23 Illinois Department shall by rule adjust disproportionate  
24 share adjustment payments.

25 (j) University of Illinois Hospital inpatient adjustment  
26 payments. For hospitals organized under the University of

1 Illinois Hospital Act, there shall be an adjustment payment as  
2 determined by rules adopted by the Illinois Department.

3 (k) The Illinois Department may by rule establish criteria  
4 for and develop methodologies for adjustment payments to  
5 hospitals participating under this Article.

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

11 (m) The Department shall establish a cost-based  
12 reimbursement methodology for determining payments to  
13 hospitals for approved graduate medical education (GME)  
14 programs for dates of service on and after July 1, 2018.

15 (1) As used in this subsection, "hospitals" means the  
16 University of Illinois Hospital as defined in the  
17 University of Illinois Hospital Act and a county hospital  
18 in a county of over 3,000,000 inhabitants.

19 (2) An amendment to the Illinois Title XIX State Plan  
20 defining GME shall maximize reimbursement, shall not be  
21 limited to the education programs or special patient care  
22 payments allowed under Medicare, and shall include:

23 (A) inpatient days;

24 (B) outpatient days;

25 (C) direct costs;

26 (D) indirect costs;

1           (E) managed care days;

2           (F) all stages of medical training and education  
3           including students, interns, residents, and fellows  
4           with no caps on the number of persons who may qualify;  
5           and

6           (G) patient care payments related to the  
7           complexities of treating Medicaid enrollees including  
8           clinical and social determinants of health.

9           (3) The Department shall make all GME payments directly  
10          to hospitals including such costs in support of clients  
11          enrolled in Medicaid managed care entities.

12          (4) The Department shall promptly take all actions  
13          necessary for reimbursement to be effective for dates of  
14          service on and after July 1, 2018 including publishing all  
15          appropriate public notices, amendments to the Illinois  
16          Title XIX State Plan, and adoption of administrative rules  
17          if necessary.

18          (5) As used in this subsection, "managed care days"  
19          means costs associated with services rendered to enrollees  
20          of Medicaid managed care entities. "Medicaid managed care  
21          entities" means any entity which contracts with the  
22          Department to provide services paid for on a capitated  
23          basis. "Medicaid managed care entities" includes a managed  
24          care organization and a managed care community network.

25          (6) All payments under this Section are contingent upon  
26          federal approval of changes to the Illinois Title XIX State



1 Plan, if that approval is required.

2 (7) The Department may adopt rules necessary to  
3 implement this amendatory Act of the 100th General Assembly  
4 through the use of emergency rulemaking in accordance with  
5 subsection (aa) of Section 5-45 of the Illinois  
6 Administrative Procedure Act. For purposes of that Act, the  
7 General Assembly finds that the adoption of rules to  
8 implement this amendatory Act of the 100th General Assembly  
9 is deemed an emergency and necessary for the public  
10 interest, safety, and welfare.

11 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

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%.

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

25 (1) "Charity percent" means the ratio of (i) the

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

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

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

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

24 (c) Beginning July 1, 2012 and ending on June 30, 2020  
25 ~~2018~~, a hospital that would have qualified for the rate year  
26 beginning October 1, 2011, shall be a Safety-Net Hospital.

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

5 (e) The Department may promulgate rules in order to  
6 implement this Section.

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

12 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;  
13 98-651, eff. 6-16-14.)

14 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

15 (Section scheduled to be repealed on July 1, 2018)

16 Sec. 5A-2. Assessment.

17 (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal  
18 years 2009 through 2018, or as long as continued under Section  
19 5A-16, an annual assessment on inpatient services is imposed on  
20 each hospital provider in an amount equal to \$218.38 multiplied  
21 by the difference of the hospital's occupied bed days less the  
22 hospital's Medicare bed days, provided, however, that the  
23 amount of \$218.38 shall be increased by a uniform percentage to  
24 generate an amount equal to 75% of the State share of the  
25 payments authorized under Section 5A-12.5, with such increase

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

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

17 For State fiscal years 2009 through 2018 ~~2014 and after~~, or  
18 as provided in Section 5A-16, a hospital's occupied bed days  
19 and Medicare bed days shall be determined using the most recent  
20 data available from each hospital's 2005 Medicare cost report  
21 as contained in the Healthcare Cost Report Information System  
22 file, for the quarter ending on December 31, 2006, without  
23 regard to any subsequent adjustments or changes to such data.  
24 If a hospital's 2005 Medicare cost report is not contained in  
25 the Healthcare Cost Report Information System, then the  
26 Illinois Department may obtain the hospital provider's

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

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

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

13 Subject to Sections 5A-3 and 5A-10, for State fiscal years  
14 2021 through 2024, an annual assessment on inpatient services  
15 is imposed on each hospital provider in an amount equal to  
16 \$197.19 multiplied by the difference of the hospital's occupied  
17 bed days less the hospital's Medicare bed days, provided  
18 however, that the amount of \$197.19 used to calculate the  
19 assessment under this paragraph shall, by rule, be adjusted by  
20 a uniform percentage to generate the same total annual  
21 assessment that was generated in State fiscal year 2020 from  
22 all hospitals subject to the annual assessment under this  
23 paragraph plus \$6,250,000. For State fiscal years 2021 and  
24 2022, a hospital's occupied bed days and Medicare bed days  
25 shall be determined using the most recent data available from  
26 each hospital's 2017 Medicare cost report as contained in the

1 Healthcare Cost Report Information System file, for the quarter  
2 ending on March 31, 2019, without regard to any subsequent  
3 adjustments or changes to such data. For State fiscal years  
4 2023 and 2024, a hospital's occupied bed days and Medicare bed  
5 days shall be determined using the most recent data available  
6 from each hospital's 2019 Medicare cost report as contained in  
7 the Healthcare Cost Report Information System file, for the  
8 quarter ending on March 31, 2021, without regard to any  
9 subsequent adjustments or changes to such data.

10 (b) (Blank).

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

1 For the period of April through June 2015, the amount of  
2 .008766 used to calculate the assessment under this paragraph  
3 shall, by emergency rule under subsection (s) of Section 5-45  
4 of the Illinois Administrative Procedure Act, be increased by a  
5 uniform percentage to generate \$6,750,000 in the aggregate for  
6 that period from all hospitals subject to the annual assessment  
7 under this paragraph.

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

15 For the portion of State fiscal year 2012, beginning June  
16 10, 2012 through June 30, 2012, and State fiscal years 2013  
17 through 2018, or as provided in Section 5A-16, a hospital's  
18 outpatient gross revenue shall be determined using the most  
19 recent data available from each hospital's 2009 Medicare cost  
20 report as contained in the Healthcare Cost Report Information  
21 System file, for the quarter ending on June 30, 2011, without  
22 regard to any subsequent adjustments or changes to such data.  
23 If a hospital's 2009 Medicare cost report is not contained in  
24 the Healthcare Cost Report Information System, then the  
25 Department may obtain the hospital provider's outpatient gross  
26 revenue from any source available, including, but not limited



1 to, records maintained by the hospital provider, which may be  
2 inspected at all times during business hours of the day by the  
3 Department or its duly authorized agents and employees.

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

1 report, but paid an assessment in State fiscal year 2018 on the  
2 basis of hypothetical data, that assessment amount shall be  
3 used for State fiscal years 2019 and 2020; however, for State  
4 fiscal year 2020, the assessment amount shall be increased by  
5 the proportion that it represents of the total annual  
6 assessment that is generated from all hospitals in order to  
7 generate \$6,250,000 in the aggregate for that period from all  
8 hospitals subject to the annual assessment under this  
9 paragraph.

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

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

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

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

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

1 and payable in the month of April 2016 multiplied by 6 as  
2 described in subparagraph (A).

3 (C) For the period of July 1, 2017 through December 31,  
4 2017, the product of .19125 multiplied by the sum of the  
5 fee-for-service payments to hospitals as authorized under  
6 Section 5A-12.5 and the adjustments authorized under  
7 subsection (t) of Section 5A-12.2 to managed care  
8 organizations for hospital services due and payable in the  
9 month of April 2017 multiplied by 6, except that the amount  
10 calculated under this subparagraph (C) shall be adjusted,  
11 either positively or negatively, to account for the  
12 difference between the actual payments issued under  
13 Section 5A-12.5 for the period beginning January 1, 2017  
14 through June 30, 2017 and the estimated payments due and  
15 payable in the month of October 2016 multiplied by 6 as  
16 described in subparagraph (B).

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

24 (i) the amount calculated under this subparagraph

25 (D) shall be adjusted, either positively or  
26 negatively, to account for the difference between the

1 actual payments issued under Section 5A-12.5 for the  
2 period of July 1, 2017 through December 31, 2017 and  
3 the estimated payments due and payable in the month of  
4 April 2017 multiplied by 6 as described in subparagraph  
5 (C); and

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

11 (2) The Department shall complete and apply a final  
12 reconciliation of the ACA Assessment Adjustment prior to June  
13 30, 2018 to account for:

14 (A) any differences between the actual payments issued  
15 or scheduled to be issued prior to June 30, 2018 as  
16 authorized in Section 5A-12.5 for the period of January 1,  
17 2018 through June 30, 2018 and the estimated payments due  
18 and payable in the month of October 2017 multiplied by 6 as  
19 described in subparagraph (D); and

20 (B) any difference between the estimated  
21 fee-for-service payments under subsection (b) of Section  
22 5A-12.5 and the amount of such payments that are actually  
23 scheduled to be paid.

24 The Department shall notify hospitals of any additional  
25 amounts owed or reduction credits to be applied to the June  
26 2018 ACA Assessment Adjustment. This is to be considered the

1 final reconciliation for the ACA Assessment Adjustment.

2 (3) Notwithstanding any other provision of this Section, if  
3 for any reason the scheduled payments under subsection (b) of  
4 Section 5A-12.5 are not issued in full by the final day of the  
5 period authorized under subsection (b) of Section 5A-12.5,  
6 funds collected from each hospital pursuant to subparagraph (D)  
7 of paragraph (1) and pursuant to paragraph (2), attributable to  
8 the scheduled payments authorized under subsection (b) of  
9 Section 5A-12.5 that are not issued in full by the final day of  
10 the period attributable to each payment authorized under  
11 subsection (b) of Section 5A-12.5, shall be refunded.

12 (4) The increases authorized under paragraph (2) of  
13 subsection (a) and paragraph (2) of subsection (b-5) shall be  
14 limited to the federally required State share of the total  
15 payments authorized under Section 5A-12.5 if the sum of such  
16 payments yields an annualized amount equal to or less than  
17 \$450,000,000, or if the adjustments authorized under  
18 subsection (t) of Section 5A-12.2 are found not to be  
19 actuarially sound; however, this limitation shall not apply to  
20 the fee-for-service payments described in subsection (b) of  
21 Section 5A-12.5.

22 (c) (Blank).

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

1 Procedure Act.

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

1 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-2,  
2 eff. 3-26-15; 99-516, eff. 6-30-16.)

3 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

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

14 Except as provided in subsection (a-5) of this Section, the  
15 assessment imposed by subsection (b-5) of Section 5A-2 for the  
16 portion of State fiscal year 2012 beginning June 10, 2012  
17 through June 30, 2012, and for State fiscal year 2013 through  
18 State fiscal year 2018 or as provided in Section 5A-16, ~~and~~  
19 ~~each subsequent State fiscal year~~ shall be due and payable in  
20 monthly installments, each equaling one-twelfth of the  
21 assessment for the year, on the 14th State business day of each  
22 month. No installment payment of an assessment imposed by  
23 subsection (b-5) of Section 5A-2 shall be due and payable,  
24 however, until after: (i) the Department notifies the hospital  
25 provider, in writing, that the payment methodologies to



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

16 Except as provided in subsection (a-5) of this Section, the  
17 assessment imposed under Section 5A-2 for State fiscal year  
18 2019 and each subsequent State fiscal year shall be due and  
19 payable in monthly installments, each equaling one-twelfth of  
20 the assessment for the year, on the 14th State business day of  
21 each month. No installment payment of an assessment imposed by  
22 Section 5A-2 shall be due and payable, however, until after:  
23 (i) the Department notifies the hospital provider, in writing,  
24 that the payment methodologies to hospitals required under  
25 Section 5A-12.6 have been approved by the Centers for Medicare  
26 and Medicaid Services of the U.S. Department of Health and

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

13 (a-5) The Illinois Department may accelerate the schedule  
14 upon which assessment installments are due and payable by  
15 hospitals with a payment ratio greater than or equal to one.  
16 Such acceleration of due dates for payment of the assessment  
17 may be made only in conjunction with a corresponding  
18 acceleration in access payments identified in Section 5A-12.2,  
19 ~~or~~ Section 5A-12.4, or Section 5A-12.6 to the same hospitals.  
20 For the purposes of this subsection (a-5), a hospital's payment  
21 ratio is defined as the quotient obtained by dividing the total  
22 payments for the State fiscal year, as authorized under Section  
23 5A-12.2, ~~or~~ Section 5A-12.4, or Section 5A-12.6, by the total  
24 assessment for the State fiscal year imposed under Section 5A-2  
25 or subsection (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. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;  
26 98-104, eff. 7-22-13.)

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

2 Sec. 5A-5. Notice; penalty; maintenance of records.

3 (a) The Illinois Department shall send a notice of  
4 assessment to every hospital provider subject to assessment  
5 under this Article. The notice of assessment shall notify the  
6 hospital of its assessment and shall be sent after receipt by  
7 the Department of notification from the Centers for Medicare  
8 and Medicaid Services of the U.S. Department of Health and  
9 Human Services that the payment methodologies required under  
10 this Article and, if necessary, the waiver granted under 42 CFR  
11 433.68 have been approved. The notice shall be on a form  
12 prepared by the Illinois Department and shall state the  
13 following:

14 (1) The name of the hospital provider.

15 (2) The address of the hospital provider's principal  
16 place of business from which the provider engages in the  
17 occupation of hospital provider in this State, and the name  
18 and address of each hospital operated, conducted, or  
19 maintained by the provider in this State.

20 (3) The occupied bed days, occupied bed days less  
21 Medicare days, adjusted gross hospital revenue, or  
22 outpatient gross revenue of the hospital provider  
23 (whichever is applicable), the amount of assessment  
24 imposed under Section 5A-2 for the State fiscal year for  
25 which the notice is sent, and the amount of each

1           installment to be paid during the State fiscal year.

2           (4) (Blank).

3           (5) Other reasonable information as determined by the  
4           Illinois Department.

5           (b) If a hospital provider conducts, operates, or maintains  
6           more than one hospital licensed by the Illinois Department of  
7           Public Health, the provider shall pay the assessment for each  
8           hospital separately.

9           (c) Notwithstanding any other provision in this Article, in  
10          the case of a person who ceases to conduct, operate, or  
11          maintain a hospital in respect of which the person is subject  
12          to assessment under this Article as a hospital provider, the  
13          assessment for the State fiscal year in which the cessation  
14          occurs shall be adjusted by multiplying the assessment computed  
15          under Section 5A-2 by a fraction, the numerator of which is the  
16          number of days in the year during which the provider conducts,  
17          operates, or maintains the hospital and the denominator of  
18          which is 365. Immediately upon ceasing to conduct, operate, or  
19          maintain a hospital, the person shall pay the assessment for  
20          the year as so adjusted (to the extent not previously paid).

21          (d) Notwithstanding any other provision in this Article, a  
22          provider who commences conducting, operating, or maintaining a  
23          hospital, upon notice by the Illinois Department, shall pay the  
24          assessment computed under Section 5A-2 and subsection (e) in  
25          installments on the due dates stated in the notice and on the  
26          regular installment due dates for the State fiscal year

1 occurring after the due dates of the initial notice.

2 (e) Notwithstanding any other provision in this Article,  
3 for State fiscal years 2009 through 2018, in the case of a  
4 hospital provider that did not conduct, operate, or maintain a  
5 hospital in 2005, the assessment for that State fiscal year  
6 shall be computed on the basis of hypothetical occupied bed  
7 days for the full calendar year as determined by the Illinois  
8 Department. Notwithstanding any other provision in this  
9 Article, for the portion of State fiscal year 2012 beginning  
10 June 10, 2012 through June 30, 2012, and for State fiscal years  
11 2013 through 2018, in the case of a hospital provider that did  
12 not conduct, operate, or maintain a hospital in 2009, the  
13 assessment under subsection (b-5) of Section 5A-2 for that  
14 State fiscal year shall be computed on the basis of  
15 hypothetical gross outpatient revenue for the full calendar  
16 year as determined by the Illinois Department.

17 Notwithstanding any other provision in this Article, for  
18 State fiscal years 2019 through 2024, in the case of a hospital  
19 provider that did not conduct, operate, or maintain a hospital  
20 in the year that is the basis of the calculation of the  
21 assessment under this Article, the assessment under paragraph  
22 (3) of subsection (a) of Section 5A-2 for the State fiscal year  
23 shall be computed on the basis of hypothetical occupied bed  
24 days for the full calendar year as determined by the Illinois  
25 Department, except that for a hospital provider that did not  
26 have a 2015 Medicare cost report, but paid an assessment in

1 State fiscal year 2018 on the basis of hypothetical data, that  
2 assessment amount shall be used for State fiscal years 2019 and  
3 2020; however, for State fiscal year 2020, the assessment  
4 amount shall be increased by the proportion that it represents  
5 of the total annual assessment that is generated from all  
6 hospitals in order to generate \$6,250,000 in the aggregate for  
7 that period from all hospitals subject to the annual assessment  
8 under this paragraph.

9 Notwithstanding any other provision in this Article, for  
10 State fiscal years 2019 through 2024, in the case of a hospital  
11 provider that did not conduct, operate, or maintain a hospital  
12 in the year that is the basis of the calculation of the  
13 assessment under this Article, the assessment under subsection  
14 (b-5) of Section 5A-2 for that State fiscal year shall be  
15 computed on the basis of hypothetical gross outpatient revenue  
16 for the full calendar year as determined by the Illinois  
17 Department, except that for a hospital provider that did not  
18 have a 2015 Medicare cost report, but paid an assessment in  
19 State fiscal year 2018 on the basis of hypothetical data, that  
20 assessment amount shall be used for State fiscal years 2019 and  
21 2020; however, for State fiscal year 2020, the assessment  
22 amount shall be increased by the proportion that it represents  
23 of the total annual assessment that is generated from all  
24 hospitals in order to generate \$6,250,000 in the aggregate for  
25 that period from all hospitals subject to the annual assessment  
26 under this paragraph.

1 (f) Every hospital provider subject to assessment under  
2 this Article shall keep sufficient records to permit the  
3 determination of adjusted gross hospital revenue for the  
4 hospital's fiscal year. All such records shall be kept in the  
5 English language and shall, at all times during regular  
6 business hours of the day, be subject to inspection by the  
7 Illinois Department or its duly authorized agents and  
8 employees.

9 (g) The Illinois Department may, by rule, provide a  
10 hospital provider a reasonable opportunity to request a  
11 clarification or correction of any clerical or computational  
12 errors contained in the calculation of its assessment, but such  
13 corrections shall not extend to updating the cost report  
14 information used to calculate the assessment.

15 (h) (Blank).

16 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;  
17 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.  
18 7-20-15.)

19 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

25 (b) The Fund is created for the purpose of receiving moneys



1 in accordance with Section 5A-6 and disbursing moneys only for  
2 the following purposes, notwithstanding any other provision of  
3 law:

4 (1) For making payments to hospitals as required under  
5 this Code, under the Children's Health Insurance Program  
6 Act, under the Covering ALL KIDS Health Insurance Act, and  
7 under the Long Term Acute Care Hospital Quality Improvement  
8 Transfer Program Act.

9 (2) For the reimbursement of moneys collected by the  
10 Illinois Department from hospitals or hospital providers  
11 through error or mistake in performing the activities  
12 authorized under this Code.

13 (3) For payment of administrative expenses incurred by  
14 the Illinois Department or its agent in performing  
15 activities under this Code, under the Children's Health  
16 Insurance Program Act, under the Covering ALL KIDS Health  
17 Insurance Act, and under the Long Term Acute Care Hospital  
18 Quality Improvement Transfer Program Act.

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

22 (5) For making transfers, as those transfers are  
23 authorized in the proceedings authorizing debt under the  
24 Short Term Borrowing Act, but transfers made under this  
25 paragraph (5) shall not exceed the principal amount of debt  
26 issued in anticipation of the receipt by the State of

1 moneys to be deposited into the Fund.

2 (6) For making transfers to any other fund in the State  
3 treasury, but transfers made under this paragraph (6) shall  
4 not exceed the amount transferred previously from that  
5 other fund into the Hospital Provider Fund plus any  
6 interest that would have been earned by that fund on the  
7 monies that had been transferred.

8 (6.5) For making transfers to the Healthcare Provider  
9 Relief Fund, except that transfers made under this  
10 paragraph (6.5) shall not exceed \$60,000,000 in the  
11 aggregate.

12 (7) For making transfers not exceeding the following  
13 amounts, related to State fiscal years 2013 through 2018,  
14 to the following designated funds:

|    |  |               |
|----|--|---------------|
| 15 | Health and Human Services Medicaid Trust |               |
| 16 | Fund .....                               | \$20,000,000  |
| 17 | Long-Term Care Provider Fund .....       | \$30,000,000  |
| 18 | General Revenue Fund .....               | \$80,000,000. |

19 Transfers under this paragraph shall be made within 7 days  
20 after the payments have been received pursuant to the  
21 schedule of payments provided in subsection (a) of Section  
22 5A-4.

23 (7.1) (Blank).

24 (7.5) (Blank).

25 (7.8) (Blank).

26 (7.9) (Blank).

1           (7.10) For State fiscal year 2014, for making transfers  
2 of the moneys resulting from the assessment under  
3 subsection (b-5) of Section 5A-2 and received from hospital  
4 providers under Section 5A-4 and transferred into the  
5 Hospital Provider Fund under Section 5A-6 to the designated  
6 funds not exceeding the following amounts in that State  
7 fiscal year:

8           Healthcare Provider Relief Fund . . . . . \$100,000,000

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           The additional amount of transfers in this paragraph  
14 (7.10), authorized by Public Act 98-651, shall be made  
15 within 10 State business days after June 16, 2014 (the  
16 effective date of Public Act 98-651). That authority shall  
17 remain in effect even if Public Act 98-651 does not become  
18 law until State fiscal year 2015.

19           (7.10a) For State fiscal years 2015 through 2018, for  
20 making transfers of the moneys resulting from the  
21 assessment under subsection (b-5) of Section 5A-2 and  
22 received from hospital providers under Section 5A-4 and  
23 transferred into the Hospital Provider Fund under Section  
24 5A-6 to the designated funds not exceeding the following  
25 amounts related to each State fiscal year:

26           Healthcare Provider Relief Fund . . . . . \$50,000,000

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

5 (7.11) (Blank).

6 (7.12) For State fiscal year 2013, for increasing by  
7 21/365ths the transfer of the moneys resulting from the  
8 assessment under subsection (b-5) of Section 5A-2 and  
9 received from hospital providers under Section 5A-4 for the  
10 portion of State fiscal year 2012 beginning June 10, 2012  
11 through June 30, 2012 and transferred into the Hospital  
12 Provider Fund under Section 5A-6 to the designated funds  
13 not exceeding the following amounts in that State fiscal  
14 year:

15 Healthcare Provider Relief Fund ..... \$2,870,000

16 Since the federal Centers for Medicare and Medicaid  
17 Services approval of the assessment authorized under  
18 subsection (b-5) of Section 5A-2, received from hospital  
19 providers under Section 5A-4 and the payment methodologies  
20 to hospitals required under Section 5A-12.4 was not  
21 received by the Department until State fiscal year 2014 and  
22 since the Department made retroactive payments during  
23 State fiscal year 2014 related to the referenced period of  
24 June 2012, the transfer authority granted in this paragraph  
25 (7.12) is extended through the date that is 10 State  
26 business days after June 16, 2014 (the effective date of

1 Public Act 98-651).

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

12 (7.14) For making transfers not exceeding the  
13 following amounts, related to State fiscal years 2019  
14 through 2024, to the following designated funds:

|    |   |                       |
|----|---|-----------------------|
| 15 | <u>Health and Human Services Medicaid Trust</u> |                       |
| 16 | <u>Fund .....</u>                               | <u>\$20,000,000</u>   |
| 17 | <u>Long-Term Care Provider Fund .....</u>       | <u>\$30,000,000</u>   |
| 18 | <u>Health Care Provider Relief Fund ..</u>      | <u>\$325,000,000.</u> |

19 Transfers under this paragraph shall be made within 7  
20 days after the payments have been received pursuant to the  
21 schedule of payments provided in subsection (a) of Section  
22 5A-4.

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

25 (9) For making payment to capitated managed care  
26 organizations as described in subsections (s) and (t) of

1 Section 5A-12.2 and subsection (r) of Section 5A-12.6 of  
2 this Code.

3 Disbursements from the Fund, other than transfers  
4 authorized under paragraphs (5) and (6) of this subsection,  
5 shall be by warrants drawn by the State Comptroller upon  
6 receipt of vouchers duly executed and certified by the Illinois  
7 Department.

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

9 (1) All moneys collected or received by the Illinois  
10 Department from the hospital provider assessment imposed  
11 by this Article.

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

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

18 (3.5) As applicable, proceeds from surety bond  
19 payments payable to the Department as referenced in  
20 subsection (s) of Section 5A-12.2 of this Code.

21 (4) Moneys transferred from another fund in the State  
22 treasury.

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

25 (d) (Blank).

26 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;

1 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.  
2 7-20-15; 99-516, eff. 6-30-16; 99-933, eff. 1-27-17; revised  
3 2-15-17.)

4 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

5 Sec. 5A-10. Applicability.

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

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

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

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

23 (B) any rates for payments made under this Article  
24 V-A;

25 (C) any changes proposed in State plan amendment

1 transmittal numbers 08-01, 08-02, 08-04, 08-06, and  
2 08-07;

3 (D) in relation to any admissions on or after  
4 January 1, 2011, a modification in the methodology for  
5 calculating outlier payments to hospitals for  
6 exceptionally costly stays, for hospitals reimbursed  
7 under the diagnosis-related grouping methodology in  
8 effect on July 1, 2011; provided that the Department  
9 shall be limited to one such modification during the  
10 36-month period after the effective date of this  
11 amendatory Act of the 96th General Assembly;

12 (E) any changes affecting hospitals authorized by  
13 Public Act 97-689;

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

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

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



1 shall be refunded to hospital providers in proportion to the  
2 amounts paid by them.

3 (c) The assessments imposed by subsection (b-5) of Section  
4 5A-2 shall not take effect or shall cease to be imposed, the  
5 Department's obligation to make payments shall immediately  
6 cease, and any moneys remaining in the Fund shall be refunded  
7 to hospital providers in proportion to the amounts paid by  
8 them, if the payments to hospitals required under Section  
9 5A-12.4 or Section 5A-12.6 are not eligible for federal  
10 matching funds under Title XIX of the Social Security Act.

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

16 (1) for State fiscal years 2013 through 2018, and as  
17 provided in Section 5A-16, the Department reduces any  
18 payment rates to hospitals as in effect on May 1, 2012, or  
19 alters any payment methodology as in effect on May 1, 2012,  
20 that has the effect of reducing payment rates to hospitals,  
21 except for any changes affecting hospitals authorized in  
22 Public Act 97-689 and any changes authorized by Section  
23 14-12 of this Code, and except for any changes authorized  
24 under Section 5A-15, and except for any changes authorized  
25 under Section 5-5b.1;

26 (2) for State fiscal years 2013 through 2018, and as

1 provided in Section 5A-16, the Department reduces any  
2 supplemental payments made to hospitals below the amounts  
3 paid for services provided in State fiscal year 2011 as  
4 implemented by administrative rules adopted and in effect  
5 on or prior to June 30, 2011, except for any changes  
6 affecting hospitals authorized in Public Act 97-689 and any  
7 changes authorized by Section 14-12 of this Code, and  
8 except for any changes authorized under Section 5A-15, and  
9 except for any changes authorized under Section 5-5b.1; or

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

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

23 (1) the payments to hospitals required under Section  
24 5A-12.6 are not eligible for federal matching funds under  
25 Title XIX of the Social Security Act; or

26 (2) the Department reduces the overall effective rate

1       of reimbursement to hospitals below the level authorized  
2       under Section 14-12 of this Code, as in effect on December  
3       31, 2017, except for any changes authorized under Sections  
4       14-12 or Section 5A-15 of this Code, and except for any  
5       changes authorized under changes to Sections 5A-12.2,  
6       5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by this  
7       amendatory Act of the 100th General Assembly.

8       (Source: P.A. 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 99-2,  
9       eff. 3-26-15.)

10       (305 ILCS 5/5A-12.5)

11       Sec. 5A-12.5. Affordable Care Act adults; hospital access  
12       payments.

13       (a) The Department shall, subject to federal approval,  
14       mirror the Medical Assistance hospital reimbursement  
15       methodology for Affordable Care Act adults who are enrolled  
16       under a fee-for-service or capitated managed care program,  
17       including hospital access payments as defined in Section  
18       5A-12.2 of this Article and hospital access improvement  
19       payments as defined in Section 5A-12.4 of this Article, in  
20       compliance with the equivalent rate provisions of the  
21       Affordable Care Act.

22       (b) If the fee-for-service payments authorized under this  
23       Section are deemed to be increases to payments for a prior  
24       period, the Department shall seek federal approval to issue  
25       such increases for the payments made through the period ending

1 on June 30, 2018, or as provided in Section 5A-16, even if such  
2 increases are paid out during an extended payment period beyond  
3 such date. Payment of such increases beyond such date is  
4 subject to federal approval. If the Department receives federal  
5 approval of such increases, the Department shall pay such  
6 increases on the same schedule as it had used for such payments  
7 prior to June 30, 2018.

8 (c) As used in this Section, "Affordable Care Act" is the  
9 collective term for the Patient Protection and Affordable Care  
10 Act (Pub. L. 111-148) and the Health Care and Education  
11 Reconciliation Act of 2010 (Pub. L. 111-152).

12 (Source: P.A. 98-651, eff. 6-16-14; 99-516, eff. 6-30-16.)

13 (305 ILCS 5/5A-12.6 new)

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

16 (a) To preserve and improve access to hospital services,  
17 for hospital services rendered on or after July 1, 2018 the  
18 Department shall, except for hospitals described in subsection  
19 (b) of Section 5A-3, make payments to hospitals as set forth in  
20 this Section. Payments under this Section are not due and  
21 payable, however, until (i) the methodologies described in this  
22 Section are approved by the federal government in an  
23 appropriate State Plan amendment and (ii) the assessment  
24 imposed under this Article is determined to be a permissible  
25 tax under Title XIX of the Social Security Act. In determining

1 the hospital access payments authorized under subsections (f)  
2 through (n) of this Section, unless otherwise specified, only  
3 Illinois hospitals shall be eligible for a payment and total  
4 Medicaid utilization statistics shall be used to determine the  
5 payment amount. In determining the hospital access payments  
6 authorized under subsection (d) and subsections (f) through (l)  
7 of this Section, if a hospital ceases to receive payments from  
8 the pool, the payments for all hospitals continuing to receive  
9 payments from such pool shall be uniformly adjusted to fully  
10 expend the aggregate amount of the pool, with such adjustment  
11 being effective on the first day of the second month following  
12 the date the hospital ceases to receive payments from such  
13 pool.

14 (b) Phase in of funds to claims-based payments and updates.  
15 To ensure access to hospital services, the Department may only  
16 use funds financed by the assessment authorized under Section  
17 5A-2 to increase claims-based payment rates, including  
18 applicable policy add-on payments or adjusters, in accordance  
19 with this subsection. To increase the claims-based payment  
20 rates up to the amounts specified in this subsection, the  
21 hospital access payments authorized in subsection (d) and  
22 subsections (g) through (l) of this Section shall be uniformly  
23 reduced.

24 (1) For State fiscal years 2019 and 2020, up to  
25 \$635,000,000 of the total spending financed from the  
26 assessment authorized under Section 5A-2 that is intended

1       to pay for hospital services and the hospital supplemental  
2       access payments authorized under subsections (d) and (f) of  
3       Section 14-12 for payment in State fiscal year 2018 may be  
4       used to increase claims-based hospital payment rates as  
5       specified under Section 14-12.

6       (2) For State fiscal years 2021 and 2022, up to  
7       \$1,164,000,000 of the total spending financed from the  
8       assessment authorized under Section 5A-2 that is intended  
9       to pay for hospital services and the hospital supplemental  
10       access payments authorized under subsections (d) and (f) of  
11       Section 14-12 for payment in State Fiscal Year 2018 may be  
12       used to increase claims-based hospital payment rates as  
13       specified under Section 14-12.

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

22       (4) For State fiscal years 2024, up to \$1,663,000,000  
23       of the total spending financed from the assessment  
24       authorized under Section 5A-2 that is intended to pay for  
25       hospital services and the hospital supplemental access  
26       payments authorized under subsections (d) and (f) of

1       Section 14-12 for payment in State Fiscal Year 2018 may be  
2       used to increase claims-based hospital payment rates as  
3       specified under Section 14-12.

4       (5) Beginning in State fiscal year 2021, and at least  
5       every 24 months thereafter, the Department shall, by rule,  
6       update the hospital access payments authorized under this  
7       Section to take into account the amount of funds being used  
8       to increase claims-based hospital payment rates under  
9       Section 14-12 and to apply the most recently available data  
10       and information, including data from the most recent base  
11       year and qualifying criteria which shall correlate to the  
12       updated base year data, to determine a hospital's  
13       eligibility for each payment and the amount of the payment  
14       authorized under this Section. Any updates of the hospital  
15       access payment methodologies shall not result in any  
16       diminishment of the aggregate amount of hospital access  
17       payment expenditures, except for reductions attributable  
18       to the use of such funds to increase claims-based hospital  
19       payment rates as authorized by this Section. Nothing in  
20       this Section shall be construed as precluding variations in  
21       the amount of any individual hospital's access payments.  
22       The Department shall publish the proposed rules to update  
23       the hospital access payments at least 90 days before their  
24       proposed effective date. The proposed rules shall not be  
25       adopted using emergency rulemaking authority. The  
26       Department shall notify each hospital, in writing, of the

1 impact of these updates on the hospital at least 30  
2 calendar days prior to their effective date.

3 (c) The hospital access payments authorized under  
4 subsections (d) through (n) of this Section shall be paid in 12  
5 equal installments on or before the seventh State business day  
6 of each month, except that no payment shall be due within 100  
7 days after the later of the date of notification of federal  
8 approval of the payment methodologies required under this  
9 Section or any waiver required under 42 CFR 433.68, at which  
10 time the sum of amounts required under this Section prior to  
11 the date of notification is due and payable. Payments under  
12 this Section are not due and payable, however, until (i) the  
13 methodologies described in this Section are approved by the  
14 federal government in an appropriate State Plan amendment and  
15 (ii) the assessment imposed under this Article is determined to  
16 be a permissible tax under Title XIX of the Social Security  
17 Act. The Department may, when practicable, accelerate the  
18 schedule upon which payments authorized under this Section are  
19 made.

20 (d) Rate increase-based adjustment.

21 (1) From the funds financed by the assessment  
22 authorized under Section 5A-2, individual funding pools by  
23 category of service shall be established, for Inpatient  
24 General Acute Care services in the amount of \$268,051,572,  
25 Inpatient Rehab Care services in the amount of \$24,500,610,  
26 Inpatient Psychiatric Care service in the amount of



1       \$94,617,812, and Outpatient Care Services in the amount of  
2       \$328,828,641.

3       (2) Each Illinois hospital and other hospitals  
4       authorized under this subsection, except for long-term  
5       acute care hospitals and public hospitals, shall be  
6       assigned a pool allocation percentage for each category of  
7       service that is equal to the ratio of the hospital's  
8       estimated FY2019 claims-based payments including all  
9       applicable FY2019 policy adjusters, multiplied by the  
10       applicable service credit factor for the hospital, divided  
11       by the total of the FY2019 claims-based payments including  
12       all FY2019 policy adjusters for each category of service  
13       adjusted by each hospital's applicable service credit  
14       factor for all qualified hospitals. For each category of  
15       service, a hospital shall receive a supplemental payment  
16       equal to its pool allocation percentage multiplied by the  
17       total pool amount.

18       (3) Effective July 1, 2018, for purposes of determining  
19       for State fiscal years 2019 and 2020 the hospitals eligible  
20       for the payments authorized under this subsection, the  
21       Department shall include children's hospitals located in  
22       St. Louis that are designated a Level III perinatal center  
23       by the Department of Public Health and also designated a  
24       Level I pediatric trauma center by the Department of Public  
25       Health as of December 1, 2017.

26       (4) As used in this subsection, "service credit factor"

1 is determined based on a hospital's Rate Year 2017 Medicaid  
2 inpatient utilization rate ("MIUR") rounded to the nearest  
3 whole percentage, as follows:

4 (A) Tier 1: A hospital with a MIUR equal to or  
5 greater than 60% shall have a service credit factor of  
6 200%.

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

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

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

15 (e) Graduate medical education.

16 (1) The calculation of graduate medical education  
17 payments shall be based on the hospital's Medicare cost  
18 report ending in Calendar Year 2015, as reported in  
19 Medicare cost reports released on October 19, 2016 with  
20 data through September 30, 2016. An Illinois hospital  
21 reporting intern and resident cost on its Medicare cost  
22 report shall be eligible for graduate medical education  
23 payments.

24 (2) Each hospital's annualized Medicaid Intern  
25 Resident Cost is calculated using annualized intern and  
26 resident total costs obtained from Worksheet B Part I,

1 Column 21 and 22 the sum of Lines 30-43, 50-76, 90-93,  
2 96-98, and 105-112 multiplied by the percentage that the  
3 hospital's Medicaid days (Worksheet S3 Part I, Column 7,  
4 Lines 14 and 16-18) comprise of the hospital's total days  
5 (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).

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

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

16 (f) Alzheimer's treatment access payment. Each Illinois  
17 academic medical center or teaching hospital, as defined in  
18 Section 5-5e.2 of this Code, that is identified as the primary  
19 hospital affiliate of one of the Regional Alzheimer's Disease  
20 Assistance Centers, as designated by the Alzheimer's Disease  
21 Assistance Act and identified in the Department of Public  
22 Health's Alzheimer's Disease State Plan dated December 2016,  
23 shall be paid an Alzheimer's treatment access payment equal to  
24 the product of \$10,000,000 multiplied by a fraction, the  
25 numerator of which is the qualifying hospital's Fiscal Year  
26 2015 total admissions and the denominator of which is the

1 Fiscal Year 2015 total admissions for all hospitals eligible  
2 for the payment.

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

5 (1) Each safety-net hospital, as defined in Section  
6 5-5e.1 of this Code, for Rate Year 2017 that is not  
7 publicly owned shall be paid an outpatient high volume  
8 access payment equal to \$40,000,000 multiplied by a  
9 fraction, the numerator of which is the hospital's Fiscal  
10 Year 2015 outpatient services and the denominator of which  
11 is the Fiscal Year 2015 outpatient services for all  
12 hospitals eligible under this paragraph for this payment.

13 (2) Each critical access hospital that is not publicly  
14 owned shall be paid an outpatient high volume access  
15 payment equal to \$55,000,000 multiplied by a fraction, the  
16 numerator of which is the hospital's Fiscal Year 2015  
17 outpatient services and the denominator of which is the  
18 Fiscal Year 2015 outpatient services for all hospitals  
19 eligible under this paragraph for this payment.

20 (3) Each tier 1 hospital that is not publicly owned  
21 shall be paid an outpatient high volume access payment  
22 equal to \$25,000,000 multiplied by a fraction, the  
23 numerator of which is the hospital's Fiscal Year 2015  
24 outpatient services and the denominator of which is the  
25 Fiscal Year 2015 outpatient services for all hospitals  
26 eligible under this paragraph for this payment. A tier 1

1       outpatient high volume hospital means one of the following:  
2       (i) a non-publicly owned hospital, excluding a safety net  
3       hospital as defined in Section 5-5e.1 of this Code for Rate  
4       Year 2017, with total outpatient services, equal to or  
5       greater than the regional mean plus one standard deviation  
6       for all hospitals in the region but less than the mean plus  
7       1.5 standard deviation; (ii) an Illinois non-publicly  
8       owned hospital with total outpatient service units equal to  
9       or greater than the statewide mean plus one standard  
10       deviation; or (iii) a non-publicly owned safety net  
11       hospital as defined in Section 5-5e.1 of this Code for Rate  
12       Year 2017, with total outpatient services, equal to or  
13       greater than the regional mean plus one standard deviation  
14       for all hospitals in the region.

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

1 region but less than the mean plus 2 standard deviations.

2 (5) Each tier 3 hospital that is not publicly owned  
3 shall be paid an outpatient high volume access payment  
4 equal to \$58,000,000 multiplied by a fraction, the  
5 numerator of which is the hospital's Fiscal Year 2015  
6 outpatient services and the denominator of which is the  
7 Fiscal Year 2015 outpatient services for all hospitals  
8 eligible under this paragraph for this payment. A tier 3  
9 outpatient high volume hospital means a non-publicly owned  
10 hospital, excluding a safety-net hospital as defined in  
11 Section 5-5e.1 of this Code for Rate Year 2017, with total  
12 outpatient services equal to or greater than the regional  
13 mean plus 2 standard deviations for all hospitals in the  
14 region.

15 (h) Medicaid dependent or high volume hospital access  
16 payment.

17 (1) To qualify for a Medicaid dependent hospital access  
18 payment, a hospital shall meet one of the following  
19 criteria:

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

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

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

4           (2) The Medicaid dependent hospital access payment  
5           shall be determined as follows:

6           (A) Each tier 1 hospital shall be paid a Medicaid  
7           dependent hospital access payment equal to \$23,000,000  
8           multiplied by a fraction, the numerator of which is the  
9           hospital's Fiscal Year 2015 total days and the  
10           denominator of which is the Fiscal Year 2015 total days  
11           for all hospitals eligible under this subparagraph for  
12           this payment. A tier 1 Medicaid dependent hospital  
13           means a qualifying hospital with a Rate Year 2017  
14           Medicaid inpatient utilization rate equal to or  
15           greater than the statewide mean but less than the  
16           statewide mean plus 0.5 standard deviation.

17           (B) Each tier 2 hospital shall be paid a Medicaid  
18           dependent hospital access payment equal to \$15,000,000  
19           multiplied by a fraction, the numerator of which is the  
20           hospital's Fiscal Year 2015 total days and the  
21           denominator of which is the Fiscal Year 2015 total days  
22           for all hospitals eligible under this subparagraph for  
23           this payment. A tier 2 Medicaid dependent hospital  
24           means a qualifying hospital with a Rate Year 2017  
25           Medicaid inpatient utilization rate equal to or  
26           greater than the statewide mean plus 0.5 standard

1           deviations but less than the statewide mean plus one  
2           standard deviation.

3           (C) Each tier 3 hospital shall be paid a Medicaid  
4           dependent hospital access payment equal to \$15,000,000  
5           multiplied by a fraction, the numerator of which is the  
6           hospital's Fiscal Year 2015 total days and the  
7           denominator of which is the Fiscal Year 2015 total days  
8           for all hospitals eligible under this subparagraph for  
9           this payment. A tier 3 Medicaid dependent hospital  
10           means a qualifying hospital with a Rate Year 2017  
11           Medicaid inpatient utilization rate equal to or  
12           greater than the statewide mean plus one standard  
13           deviation but less than the statewide mean plus 1.5  
14           standard deviations.

15           (D) Each tier 4 hospital shall be paid a Medicaid  
16           dependent hospital access payment equal to \$53,000,000  
17           multiplied by a fraction, the numerator of which is the  
18           hospital's Fiscal Year 2015 total days and the  
19           denominator of which is the Fiscal Year 2015 total days  
20           for all hospitals eligible under this subparagraph for  
21           this payment. A tier 4 Medicaid dependent hospital  
22           means a qualifying hospital with a Rate Year 2017  
23           Medicaid inpatient utilization rate equal to or  
24           greater than the statewide mean plus 1.5 standard  
25           deviations but less than the statewide mean plus 2  
26           standard deviations.



1           (E) Each tier 5 hospital shall be paid a Medicaid  
2           dependent hospital access payment equal to \$75,000,000  
3           multiplied by a fraction, the numerator of which is the  
4           hospital's Fiscal Year 2015 total days and the  
5           denominator of which is the Fiscal Year 2015 total days  
6           for all hospitals eligible under this subparagraph for  
7           this payment. A tier 5 Medicaid dependent hospital  
8           means a qualifying hospital with a Rate Year 2017  
9           Medicaid inpatient utilization rate equal to or  
10           greater than the statewide mean plus 2 standard  
11           deviations.

12           (3) Each Medicaid high volume hospital shall be paid a  
13           Medicaid high volume access payment equal to \$300,000,000  
14           multiplied by a fraction, the numerator of which is the  
15           hospital's Fiscal Year 2015 total admissions and the  
16           denominator of which is the Fiscal Year 2015 total  
17           admissions for all hospitals eligible under this paragraph  
18           for this payment. A Medicaid high volume hospital means the  
19           Illinois general acute care hospitals with the highest  
20           number of Fiscal Year 2015 total admissions that when  
21           ranked in descending order from the highest Fiscal Year  
22           2015 total admissions to the lowest Fiscal Year 2015 total  
23           admissions, in the aggregate, sum to at least 50% of the  
24           total admissions for all such hospitals in Fiscal Year  
25           2015; however, any hospital which has qualified as a  
26           Medicaid dependent hospital shall not also be considered a

1 Medicaid high volume hospital.

2 (i) Perinatal care access payment.

3 (1) Each Illinois non-publicly owned hospital  
4 designated a Level II or II+ perinatal center by the  
5 Department of Public Health as of December 1, 2017 shall be  
6 paid an access payment equal to \$200,000,000 multiplied by  
7 a fraction, the numerator of which is the hospital's Fiscal  
8 Year 2015 total admissions and the denominator of which is  
9 the Fiscal Year 2015 total admissions for all hospitals  
10 eligible under this paragraph for this payment.

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

19 (j) Trauma care access payment.

20 (1) Each Illinois non-publicly owned hospital  
21 designated a Level I trauma center by the Department of  
22 Public Health as of December 1, 2017 shall be paid an  
23 access payment equal to \$160,000,000 multiplied by a  
24 fraction, the numerator of which is the hospital's Fiscal  
25 Year 2015 total admissions and the denominator of which is  
26 the Fiscal Year 2015 total admissions for all hospitals

1 eligible under this paragraph for this payment.

2 (2) Each Illinois non-publicly owned hospital  
3 designated a Level II trauma center by the Department of  
4 Public Health as of December 1, 2017 shall be paid an  
5 access payment equal to \$200,000,000 multiplied by a  
6 fraction, the numerator of which is the hospital's Fiscal  
7 Year 2015 total admissions and the denominator of which is  
8 the Fiscal Year 2015 total admissions for all hospitals  
9 eligible under this paragraph for this payment.

10 (k) Perinatal and trauma center access payment.

11 (1) Each Illinois non-publicly owned hospital  
12 designated a Level III perinatal center and a Level I or II  
13 trauma center by the Department of Public Health as of  
14 December 1, 2017, and that has a Rate Year 2017 Medicaid  
15 inpatient utilization rate equal to or greater than 20% and  
16 a calendar year 2015 occupancy ratio equal to or greater  
17 than 50%, shall be paid an access payment equal to  
18 \$160,000,000 multiplied by a fraction, the numerator of  
19 which is the hospital's Fiscal Year 2015 total admissions  
20 and the denominator of which is the Fiscal Year 2015 total  
21 admissions for all hospitals eligible under this paragraph  
22 for this payment.

23 (2) Each Illinois non-publicly owned hospital  
24 designated a Level II or II+ perinatal center and a Level I  
25 or II trauma center by the Department of Public Health as  
26 of December 1, 2017, and that has a Rate Year 2017 Medicaid

1 inpatient utilization rate equal to or greater than 20% and  
2 a calendar year 2015 occupancy ratio equal to or greater  
3 than 50%, shall be paid an access payment equal to  
4 \$200,000,000 multiplied by a fraction, the numerator of  
5 which is the hospital's Fiscal Year 2015 total admissions  
6 and the denominator of which is the Fiscal Year 2015 total  
7 admissions for all hospitals eligible under this paragraph  
8 for this payment.

9 (l) Long-term acute care access payment. Each Illinois  
10 non-publicly owned long-term acute care hospital that has a  
11 Rate Year 2017 Medicaid inpatient utilization rate equal to or  
12 greater than 25% and a calendar year 2015 occupancy ratio equal  
13 to or greater than 60% shall be paid an access payment equal to  
14 \$19,000,000 multiplied by a fraction, the numerator of which is  
15 the hospital's Fiscal Year 2015 general acute care admissions  
16 and the denominator of which is the Fiscal Year 2015 general  
17 acute care admissions for all hospitals eligible under this  
18 subsection for this payment.

19 (m) Small public hospital access payment.

20 (1) As used in this subsection, "small public hospital"  
21 means any Illinois publicly owned hospital which is not a  
22 "large public hospital" as described in 89 Ill. Adm. Code  
23 148.25(a).

24 (2) Each small public hospital shall be paid an  
25 inpatient access payment equal to \$2,825,000 multiplied by  
26 a fraction, the numerator of which is the hospital's Fiscal

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

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

10 (n) Psychiatric care access payment. In addition to rates  
11 paid for inpatient psychiatric services, the Illinois  
12 Department shall, by rule, establish an access payment for  
13 inpatient hospital psychiatric services that shall, in the  
14 aggregate, spend approximately \$61,141,188 annually. In  
15 consultation with the hospital community, the Department may,  
16 by rule, incorporate the funds used for this access payment to  
17 increase the payment rates for inpatient psychiatric services,  
18 except that such changes shall not take effect before July 1,  
19 2019. Upon incorporation into the claims payment rates, this  
20 access payment shall be repealed. Beginning July 1, 2018, for  
21 purposes of determining for State fiscal years 2019 and 2020  
22 the hospitals eligible for the payments authorized under this  
23 subsection, the Department shall include out-of-state  
24 hospitals that are designated a Level I pediatric trauma center  
25 or a Level I trauma center by the Department of Public Health  
26 as of December 1, 2017.

1       (o) For purposes of this Section, a hospital that is  
2 enrolled to provide Medicaid services during State fiscal year  
3 2015 shall have its utilization and associated reimbursements  
4 annualized prior to the payment calculations being performed  
5 under this Section.

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

8       "General acute care admissions" means, for a given  
9 hospital, the sum of inpatient hospital admissions provided to  
10 recipients of medical assistance under Title XIX of the Social  
11 Security Act for general acute care, excluding admissions for  
12 individuals eligible for Medicare under Title XVIII of the  
13 Social Security Act (Medicaid/Medicare crossover admissions),  
14 as tabulated from the Department's paid claims data for general  
15 acute care admissions occurring during State fiscal year 2015  
16 that was adjudicated by the Department through October 28,  
17 2016.

18       "Occupancy ratio" is determined utilizing the IDPH  
19 Hospital Profile CY15 - Facility Utilization Data - Source 2015  
20 Annual Hospital Questionnaire. Utilizes all beds and days  
21 including observation days but excludes Long Term Care and  
22 Swing bed and their associated beds and days.

23       "Outpatient services" means, for a given hospital, the sum  
24 of the number of outpatient encounters identified as unique  
25 services provided to recipients of medical assistance under  
26 Title XIX of the Social Security Act for general acute care,

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

8 "Total days" means, for a given hospital, the sum of  
9 inpatient hospital days provided to recipients of medical  
10 assistance under Title XIX of the Social Security Act for  
11 general acute care, psychiatric care, and rehabilitation care,  
12 excluding days for individuals eligible for Medicare under  
13 Title XVIII of the Social Security Act (Medicaid/Medicare  
14 crossover days), as tabulated from the Department's paid claims  
15 data for total days occurring during State fiscal year 2015  
16 that was adjudicated by the Department through October 28,  
17 2016.

18 "Total admissions" means, for a given hospital, the sum of  
19 inpatient hospital admissions provided to recipients of  
20 medical assistance under Title XIX of the Social Security Act  
21 for general acute care, psychiatric care, and rehabilitation  
22 care, excluding admissions for individuals eligible for  
23 Medicare under Title XVIII of that Act (Medicaid/Medicare  
24 crossover admissions), as tabulated from the Department's paid  
25 claims data for admissions occurring during State fiscal year  
26 2015 that was adjudicated by the Department through October 28,

1 2016.

2 (q) Notwithstanding any of the other provisions of this  
3 Section, the Department is authorized to adopt rules that  
4 change the hospital access payments specified in this Section,  
5 but only to the extent necessary to conform to any federally  
6 approved amendment to the Title XIX State Plan. Any such rules  
7 shall be adopted by the Department as authorized by Section  
8 5-50 of the Illinois Administrative Procedure Act.  
9 Notwithstanding any other provision of law, any changes  
10 implemented as a result of this subsection (q) shall be given  
11 retroactive effect so that they shall be deemed to have taken  
12 effect as of the effective date of this amendatory Act of the  
13 100th General Assembly.

14 (r) On or after July 1, 2018, and no less than annually  
15 thereafter, the Department shall increase capitation payments  
16 to capitated managed care organizations (MCOs) to equal the  
17 aggregate reduction of payments made in this Section to  
18 preserve access to hospital services for recipients under the  
19 Medical Assistance Program. The aggregate amount of all  
20 increased capitation payments to all MCOs for a fiscal year  
21 shall at least be the amount needed to avoid reduction in  
22 payments authorized under Section 5A-15. Payments to MCOs under  
23 this Section shall be consistent with actuarial certification  
24 and shall be published by the Department each year. Managed  
25 care organizations and hospitals (including through their  
26 representative organizations), shall develop and implement



1 methodologies and rates for payments that will preserve and  
2 improve access to hospital services for recipients in  
3 furtherance of the State's public policy to ensure equal access  
4 to covered services to recipients under the Medical Assistance  
5 Program. The Department shall make available, on a monthly  
6 basis, a report of the capitation payments that are made to  
7 each MCO, including the number of enrollees for which such  
8 payment is made, the per enrollee amount of the payment, and  
9 any adjustments that have been made. Payments to MCOs that  
10 would be paid consistent with actuarial certification and  
11 enrollment in the absence of the increased capitation payments  
12 under this Section shall not be reduced as a consequence of  
13 payments made under this subsection.

14 As used in this subsection, "MCO" means an entity which  
15 contracts with the Department to provide services where payment  
16 for medical services is made on a capitated basis.

17 (305 ILCS 5/5A-13)

18 Sec. 5A-13. Emergency rulemaking.

19 (a) The Department of Healthcare and Family Services  
20 (formerly Department of Public Aid) may adopt rules necessary  
21 to implement this amendatory Act of the 94th General Assembly  
22 through the use of emergency rulemaking in accordance with  
23 Section 5-45 of the Illinois Administrative Procedure Act. For  
24 purposes of that Act, the General Assembly finds that the  
25 adoption of rules to implement this amendatory Act of the 94th

1 General Assembly is deemed an emergency and necessary for the  
2 public interest, safety, and welfare.

3 (b) The Department of Healthcare and Family Services may  
4 adopt rules necessary to implement this amendatory Act of the  
5 97th General Assembly through the use of emergency rulemaking  
6 in accordance with Section 5-45 of the Illinois Administrative  
7 Procedure Act. For purposes of that Act, the General Assembly  
8 finds that the adoption of rules to implement this amendatory  
9 Act of the 97th General Assembly is deemed an emergency and  
10 necessary for the public interest, safety, and welfare.

11 (c) The Department of Healthcare and Family Services may  
12 adopt rules necessary to initially implement the changes to  
13 Articles 5, 5A, 12, and 14 of this Code under this amendatory  
14 Act of the 100th General Assembly through the use of emergency  
15 rulemaking in accordance with subsection (aa) of Section 5-45  
16 of the Illinois Administrative Procedure Act. For purposes of  
17 that Act, the General Assembly finds that the adoption of rules  
18 to implement the changes to Articles 5, 5A, 12, and 14 of this  
19 Code under this amendatory Act of the 100th General Assembly is  
20 deemed an emergency and necessary for the public interest,  
21 safety, and welfare. The 24-month limitation on the adoption of  
22 emergency rules does not apply to rules adopted to initially  
23 implement the changes to Articles 5, 5A, 12, and 14 of this  
24 Code under this amendatory Act of the 100th General Assembly.  
25 For purposes of this subsection, "initially" means any  
26 emergency rules necessary to immediately implement the changes

1 authorized to Articles 5, 5A, 12, and 14 of this Code under  
2 this amendatory Act of the 100th General Assembly; however,  
3 emergency rulemaking authority shall not be used to make  
4 changes that could otherwise be made following the process  
5 established in the Illinois Administrative Procedure Act.

6 (Source: P.A. 97-688, eff. 6-14-12.)

7 (305 ILCS 5/5A-14)

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

9 (a) Section 5A-2 is repealed on July 1, 2020 ~~2018~~.

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

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

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

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

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

16 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;  
17 98-651, eff. 6-16-14.)

18 (305 ILCS 5/5A-15)

19 Sec. 5A-15. Protection of federal revenue.

20 (a) If the federal Centers for Medicare and Medicaid  
21 Services finds that any federal upper payment limit applicable  
22 to the payments under this Article is exceeded then:

23 (1) (i) if such finding is made before payments have  
24 been issued, the payments under this Article and the

1 increases in claims-based hospital payment rates specified  
2 under Section 14-12 of this Code, as authorized under this  
3 amendatory Act of the 100th General Assembly, that exceed  
4 the applicable federal upper payment limit shall be reduced  
5 uniformly to the extent necessary to comply with the  
6 applicable federal upper payment limit; or (ii) if such  
7 finding is made after payments have been issued, the  
8 payments under this Article that exceed the applicable  
9 federal upper payment limit shall be reduced uniformly to  
10 the extent necessary to comply with the applicable federal  
11 upper payment limit; and

12 (2) any assessment rate imposed under this Article  
13 shall be reduced such that the aggregate assessment is  
14 reduced by the same percentage reduction applied in  
15 paragraph (1); and

16 (3) any transfers from the Hospital Provider Fund under  
17 Section 5A-8 shall be reduced by the same percentage  
18 reduction applied in paragraph (1).

19 (b) Any payment reductions made under the authority granted  
20 in this Section are exempt from the requirements and actions  
21 under Section 5A-10.

22 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12.)

23 (305 ILCS 5/5A-16 new)

24 Sec. 5A-16. State fiscal year 2019 implementation  
25 protection. To preserve access to hospital services, it is the

1 intent of the General Assembly that there not be a gap in  
2 payments to hospitals while the changes authorized under this  
3 amendatory Act of the 100th General Assembly are being reviewed  
4 by the federal Centers for Medicare and Medicaid Services and  
5 implemented by the Department. Therefore, pending the review  
6 and approval of the changes to the assessment and hospital  
7 reimbursement methodologies authorized under this amendatory  
8 Act of the 100th General Assembly by the federal Centers for  
9 Medicare and Medicaid Services and the final implementation of  
10 such program by the Department, the Department shall take all  
11 actions necessary to continue the reimbursement methodologies  
12 and payments to hospitals that are changed under this  
13 amendatory Act of the 100th General Assembly, as they are in  
14 effect on June 30, 2018, until the first day of the second  
15 month after the new and revised methodologies and payments  
16 authorized under this amendatory Act of the 100th General  
17 Assembly are effective and implemented by the Department. Such  
18 actions by the Department shall include, but not be limited to,  
19 requesting the extension of any federal approval of the  
20 currently approved payment methodologies contained in  
21 Illinois' Medicaid State Plan while the federal Centers for  
22 Medicare and Medicaid Services reviews the proposed changes  
23 authorized under this amendatory Act of the 100th General  
24 Assembly.

25 Notwithstanding any other provision of this Code, if the  
26 federal Centers for Medicare and Medicaid Services should

1 approve the continuation of the reimbursement methodologies  
2 and payments to hospitals under Sections 5A-12.2, 5A-12.4,  
3 5A-12.5, and Section 14-12, as they are in effect on June 30,  
4 2018, until the new and revised methodologies and payments  
5 authorized under Sections 5A-12.6 and Section 14-12 of this  
6 amendatory Act of the 100th General Assembly are federally  
7 approved, then the reimbursement methodologies and payments to  
8 hospitals under Sections 5A-12.2, 5A-12.4, 5A-12.5, and 14-12,  
9 and the assessments imposed under Section 5A-2, as they are in  
10 effect on June 30, 2018, shall continue until the effective  
11 date of the new and revised methodologies and payments, which  
12 shall be the first day of the second month following the date  
13 of approval by the federal Centers for Medicare and Medicaid  
14 Services.

15 (305 ILCS 5/12-4.105)

16 Sec. 12-4.105. Human poison control center; payment  
17 program. Subject to funding availability resulting from  
18 transfers made from the Hospital Provider Fund to the  
19 Healthcare Provider Relief Fund as authorized under this Code,  
20 for State fiscal year 2017 and State fiscal year 2018, and for  
21 each State fiscal year thereafter in which the assessment under  
22 Section 5A-2 is imposed, the Department of Healthcare and  
23 Family Services shall pay to the human poison control center  
24 designated under the Poison Control System Act an amount of not  
25 less than \$3,000,000 for each of those State fiscal years that

1 the human poison control center is in operation.

2 (Source: P.A. 99-516, eff. 6-30-16.)

3 (305 ILCS 5/14-12)

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

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

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

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

23 (3) In addition to the statewide-standardized amount,  
24 the Department shall develop adjusters to adjust the rate  
25 of reimbursement for critical Medicaid providers or

1 services for trauma, transplantation services, perinatal  
2 care, and Graduate Medical Education (GME).

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

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

17 (6) Beginning July 1, 2014 and ending on June 30, 2024  
18 ~~2018~~, in addition to the statewide-standardized amount,  
19 the Department shall develop an adjustor to adjust the rate  
20 of reimbursement for safety-net hospitals defined in  
21 Section 5-5e.1 of this Code excluding pediatric hospitals.

22 (7) Beginning July 1, 2014 and ending on June 30, 2020,  
23 or upon implementation of inpatient psychiatric rate  
24 increases as described in subsection (n) of Section 5A-12.6  
25 ~~2018~~, in addition to the statewide-standardized amount,  
26 the Department shall develop an adjustor to adjust the rate



1 of reimbursement for Illinois freestanding inpatient  
2 psychiatric hospitals that are not designated as  
3 children's hospitals by the Department but are primarily  
4 treating patients under the age of 21.

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

26 (8) Beginning July 1, 2018, in addition to the

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

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

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

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

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

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

1 and paragraphs (3) and (4) of subsection (b) multiplied by  
2 0.9%.

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

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

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

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

1 be the weighting factors as published by 3M Health  
2 Information System, associated with Version 3.7.

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

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

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

23 (3) In addition to the statewide-standardized amounts,  
24 the Department shall develop adjusters to adjust the rate  
25 of reimbursement for critical Medicaid hospital outpatient  
26 providers or services, including outpatient high volume or

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

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

21      (5) Beginning July 1, 2018, the statewide-standardized  
22      amounts for outpatient services shall be increased so that  
23      base claims projected reimbursement is increased by an  
24      amount equal to the funds allocated in paragraph (1) of  
25      subsection (b) of Section 5A-12.6, less the amount  
26      allocated under paragraphs (8) and (9) of subsection (a)

1       and paragraphs (3) and (4) of this subsection multiplied by  
2       46%. Beginning July 1, 2020, the statewide-standardized  
3       amounts for outpatient services shall be increased so that  
4       base claims projected reimbursement is increased by an  
5       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 subsection (a)  
8       and paragraphs (3) and (4) of this subsection multiplied by  
9       46%. Beginning July 1, 2022, the statewide-standardized  
10       amounts for outpatient services shall be increased so that  
11       base claims projected reimbursement is increased by an  
12       amount equal to the funds allocated in paragraph (3) of  
13       subsection (b) of Section 5A-12.6, less the amount  
14       allocated under paragraphs (8) and (9) of subsection (a)  
15       and paragraphs (3) and (4) of this subsection multiplied by  
16       46%. Beginning July 1, 2023, the statewide-standardized  
17       amounts for outpatient services shall be increased so that  
18       base claims projected reimbursement is increased by an  
19       amount equal to the funds allocated in paragraph (4) of  
20       subsection (b) of Section 5A-12.6, less the amount  
21       allocated under paragraphs (8) and (9) of subsection (a)  
22       and paragraphs (3) and (4) of this subsection multiplied by  
23       46%.

24       (c) In consultation with the hospital community, the  
25       Department is authorized to replace 89 Ill. Admin. Code 152.150  
26       as published in 38 Ill. Reg. 4980 through 4986 within 12 months

1 of the effective date of this amendatory Act of the 98th  
2 General Assembly. If the Department does not replace these  
3 rules within 12 months of the effective date of this amendatory  
4 Act of the 98th General Assembly, the rules in effect for  
5 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall  
6 remain in effect until modified by rule by the Department.  
7 Nothing in this subsection shall be construed to mandate that  
8 the Department file a replacement rule.

9 (d) Transition period. There shall be a transition period  
10 to the reimbursement systems authorized under this Section that  
11 shall begin on the effective date of these systems and continue  
12 until June 30, 2018, unless extended by rule by the Department.  
13 To help provide an orderly and predictable transition to the  
14 new reimbursement systems and to preserve and enhance access to  
15 the hospital services during this transition, the Department  
16 shall allocate a transitional hospital access pool of at least  
17 \$290,000,000 annually so that transitional hospital access  
18 payments are made to hospitals.

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

24 (2) After the transition period, if the Department  
25 reduces payments from the transitional hospital access  
26 pool, it shall increase base rates, develop new adjustors,



1       adjust current adjustors, develop new hospital access  
2       payments based on updated information, or any combination  
3       thereof by an amount equal to the decreases proposed in the  
4       transitional hospital access pool payments, ensuring that  
5       the entire transitional hospital access pool amount shall  
6       continue to be used for hospital payments.

7       (d-5) Hospital transformation program. The Department, in  
8       conjunction with the Hospital Transformation Review Committee  
9       created under subsection (d-5), shall develop a hospital  
10      transformation program to provide financial assistance to  
11      hospitals in transforming their services and care models to  
12      better align with the needs of the communities they serve. The  
13      payments authorized in this Section shall be subject to  
14      approval by the federal government.

15      (1) Phase 1. In State fiscal years 2019 through 2020,  
16      the Department shall allocate funds from the transitional  
17      access hospital pool to create a hospital transformation  
18      pool of at least \$262,906,870 annually and make hospital  
19      transformation payments to hospitals. Subject to Section  
20      5A-16, in State fiscal years 2019 and 2020, an Illinois  
21      hospital that received either a transitional hospital  
22      access payment under subsection (d) or a supplemental  
23      payment under subsection (f) of this Section in State  
24      fiscal year 2018, shall receive a hospital transformation  
25      payment as follows:

26      (A) If the hospital's Rate Year 2017 Medicaid

1       inpatient utilization rate is equal to or greater than  
2       45%, the hospital transformation payment shall be  
3       equal to 100% of the sum of its transitional hospital  
4       access payment authorized under subsection (d) and any  
5       supplemental payment authorized under subsection (f).

6       (B) If the hospital's Rate Year 2017 Medicaid  
7       inpatient utilization rate is equal to or greater than  
8       25% but less than 45%, the hospital transformation  
9       payment shall be equal to 75% of the sum of its  
10       transitional hospital access payment authorized under  
11       subsection (d) and any supplemental payment authorized  
12       under subsection (f).

13       (C) If the hospital's Rate Year 2017 Medicaid  
14       inpatient utilization rate is less than 25%, the  
15       hospital transformation payment shall be equal to 50%  
16       of the sum of its transitional hospital access payment  
17       authorized under subsection (d) and any supplemental  
18       payment authorized under subsection (f).

19       (2) Phase 2. During State fiscal years 2021 and 2022,  
20       the Department shall allocate funds from the transitional  
21       access hospital pool to create a hospital transformation  
22       pool annually and make hospital transformation payments to  
23       hospitals participating in the transformation program. Any  
24       hospital may seek transformation funding in Phase 2. Any  
25       hospital that seeks transformation funding in Phase 2 to  
26       update or repurpose the hospital's physical structure to

1 transition to a new delivery model, must submit to the  
2 Department in writing a transformation plan, based on the  
3 Department's guidelines, that describes the desired  
4 delivery model with projections of patient volumes by  
5 service lines and projected revenues, expenses, and net  
6 income that correspond to the new delivery model. In Phase  
7 2, subject to the approval of rules, the Department may use  
8 the hospital transformation pool to increase base rates,  
9 develop new adjustors, adjust current adjustors, or  
10 develop new access payments in order to support and  
11 incentivize hospitals to pursue such transformation. In  
12 developing such methodologies, the Department shall ensure  
13 that the entire hospital transformation pool continues to  
14 be expended to ensure access to hospital services or to  
15 support organizations that had received hospital  
16 transformation payments under this Section.

17 (A) Any hospital participating in the hospital  
18 transformation program shall provide an opportunity  
19 for public input by local community groups, hospital  
20 workers, and healthcare professionals and assist in  
21 facilitating discussions about any transformations or  
22 changes to the hospital.

23 (B) As provided in paragraph (9) of Section 3 of  
24 the Illinois Health Facilities Planning Act, any  
25 hospital participating in the transformation program  
26 may be excluded from the requirements of the Illinois

1           Health Facilities Planning Act for those projects  
2           related to the hospital's transformation. To be  
3           eligible, the hospital must submit to the Health  
4           Facilities and Services Review Board certification  
5           from the Department, approved by the Hospital  
6           Transformation Review Committee, that the project is a  
7           part of the hospital's transformation.

8           (C) As provided in subsection (a-20) of Section  
9           32.5 of the Emergency Medical Services (EMS) Systems  
10           Act, a hospital that received hospital transformation  
11           payments under this Section may convert to a  
12           freestanding emergency center. To be eligible for such  
13           a conversion, the hospital must submit to the  
14           Department of Public Health certification from the  
15           Department, approved by the Hospital Transformation  
16           Review Committee, that the project is a part of the  
17           hospital's transformation.

18           (3) Within 6 months after the effective date of this  
19           amendatory Act of the 100th General Assembly, the  
20           Department, in conjunction with the Hospital  
21           Transformation Review Committee, shall develop and adopt,  
22           by rule, the goals, objectives, policies, standards,  
23           payment models, or criteria to be applied in Phase 2 of the  
24           program to allocate the hospital transformation funds. The  
25           goals, objectives, and policies to be considered may  
26           include, but are not limited to, achieving unmet needs of a

1 community that a hospital serves such as behavioral health  
2 services, outpatient services, or drug rehabilitation  
3 services; attaining certain quality or patient safety  
4 benchmarks for health care services; or improving the  
5 coordination, effectiveness, and efficiency of care  
6 delivery. Notwithstanding any other provision of law, any  
7 rule adopted in accordance with this subsection (d-5) may  
8 be submitted to the Joint Committee on Administrative Rules  
9 for approval only if the rule has first been approved by 9  
10 of the 14 members of the Hospital Transformation Review  
11 Committee.

12 (4) Hospital Transformation Review Committee. There is  
13 created the Hospital Transformation Review Committee. The  
14 Committee shall consist of 14 members. No later than 30  
15 days after the effective date of this amendatory Act of the  
16 100th General Assembly, the 4 legislative leaders shall  
17 each appoint 3 members; the Governor shall appoint the  
18 Director of Healthcare and Family Services, or his or her  
19 designee, as a member; and the Director of Healthcare and  
20 Family Services shall appoint one member. Any vacancy shall  
21 be filled by the applicable appointing authority within 15  
22 calendar days. The members of the Committee shall select a  
23 Chair and a Vice-Chair from among its members, provided  
24 that the Chair and Co-Chair cannot be appointed by the same  
25 appointing authority and must be from different political  
26 parties. The Chair shall have the authority to establish a

1 meeting schedule and convene meetings of the Committee, and  
2 the Vice-Chair shall have the authority to convene meetings  
3 in the absence of the Chair. The Committee may establish  
4 its own rules with respect to meeting schedule, notice of  
5 meetings, and the disclosure of documents; however, the  
6 Committee shall not have the power to subpoena individuals  
7 or documents and any rules must be approved by 9 of the 14  
8 members. The Committee shall perform the functions  
9 described in this Section and advise and consult with the  
10 Director in the administration of this Section. In addition  
11 to reviewing and approving the policies, procedures, and  
12 rules for the hospital transformation program, the  
13 Committee shall consider and make recommendations related  
14 to qualifying criteria and payment methodologies related  
15 to safety-net hospitals and children's hospitals. Members  
16 of the Committee appointed by the legislative leaders shall  
17 be subject to the jurisdiction of the Legislative Ethics  
18 Commission, not the Executive Ethics Commission, and all  
19 requests under the Freedom of Information Act shall be  
20 directed to the applicable Freedom of Information officer  
21 for the General Assembly. The Department shall provide  
22 operational support to the Committee as necessary.

23 (e) Beginning 36 months after initial implementation, the  
24 Department shall update the reimbursement components in  
25 subsections (a) and (b), including standardized amounts and  
26 weighting factors, and at least triennially and no more

1 frequently than annually thereafter. The Department shall  
2 publish these updates on its website no later than 30 calendar  
3 days prior to their effective date.

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

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

25 (h) The Department shall have the authority to modify by  
26 rulemaking any changes to the rates or methodologies in this

1 Section as required by the federal government to obtain federal  
2 financial participation for expenditures made under this  
3 Section.

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

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

26 (k) The Department shall notify each hospital and managed



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

4 (Source: P.A. 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

5 Section 95. No acceleration or delay. Where this Act makes  
6 changes in a statute that is represented in this Act by text  
7 that is not yet or no longer in effect (for example, a Section  
8 represented by multiple versions), the use of that text does  
9 not accelerate or delay the taking effect of (i) the changes  
10 made by this Act or (ii) provisions derived from any other  
11 Public Act.

12 Section 99. Effective date. This Act takes effect upon  
13 becoming law, but this Act does not take effect at all unless  
14 Senate Bill 1573 of the 100th General Assembly, as amended,  
15 becomes law."