

1 AN ACT concerning public aid.

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

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

11 In accordance with guidelines promulgated by the federal
12 Centers for Medicare and Medicaid Services, the assessment plan
13 presented shall phase in claims-based payments through
14 increasing amounts over 6 years. The Department of Healthcare
15 and Family Services, in consultation with the Hospital
16 Transformation Review Committee, the hospital community, and
17 the managed care organizations contracting with the State to
18 provide medicaid services, shall evaluate the State fiscal year
19 claims-based payments to monitor whether the proposed rates and
20 methodologies resulted in expected reimbursement estimates,
21 taking into consideration any changes in utilization patterns.

22 Section 2. The Illinois Administrative Procedure Act is
23 amended by changing Section 5-45 and by adding Section 5-46.3

1 as follows:

2 (5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

3 Sec. 5-45. Emergency rulemaking.

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

7 (b) If any agency finds that an emergency exists that
8 requires adoption of a rule upon fewer days than is required by
9 Section 5-40 and states in writing its reasons for that
10 finding, the agency may adopt an emergency rule without prior
11 notice or hearing upon filing a notice of emergency rulemaking
12 with the Secretary of State under Section 5-70. The notice
13 shall include the text of the emergency rule and shall be
14 published in the Illinois Register. Consent orders or other
15 court orders adopting settlements negotiated by an agency may
16 be adopted under this Section. Subject to applicable
17 constitutional or statutory provisions, an emergency rule
18 becomes effective immediately upon filing under Section 5-65 or
19 at a stated date less than 10 days thereafter. The agency's
20 finding and a statement of the specific reasons for the finding
21 shall be filed with the rule. The agency shall take reasonable
22 and appropriate measures to make emergency rules known to the
23 persons who may be affected by them.

24 (c) An emergency rule may be effective for a period of not
25 longer than 150 days, but the agency's authority to adopt an

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

21 (c-5) To facilitate the maintenance of the program of group
22 health benefits provided to annuitants, survivors, and retired
23 employees under the State Employees Group Insurance Act of
24 1971, rules to alter the contributions to be paid by the State,
25 annuitants, survivors, retired employees, or any combination
26 of those entities, for that program of group health benefits,

1 shall be adopted as emergency rules. The adoption of those
2 rules shall be considered an emergency and necessary for the
3 public interest, safety, and welfare.

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

16 (e) In order to provide for the expeditious and timely
17 implementation of the State's fiscal year 2000 budget,
18 emergency rules to implement any provision of Public Act 91-24
19 or any other budget initiative for fiscal year 2000 may be
20 adopted in accordance with this Section by the agency charged
21 with administering that provision or initiative, except that
22 the 24-month limitation on the adoption of emergency rules and
23 the provisions of Sections 5-115 and 5-125 do not apply to
24 rules adopted under this subsection (e). The adoption of
25 emergency rules authorized by this subsection (e) shall be
26 deemed to be necessary for the public interest, safety, and

1 welfare.

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

14 (g) In order to provide for the expeditious and timely
15 implementation of the State's fiscal year 2002 budget,
16 emergency rules to implement any provision of Public Act 92-10
17 or any other budget initiative for fiscal year 2002 may be
18 adopted in accordance with this Section by the agency charged
19 with administering that provision or initiative, except that
20 the 24-month limitation on the adoption of emergency rules and
21 the provisions of Sections 5-115 and 5-125 do not apply to
22 rules adopted under this subsection (g). The adoption of
23 emergency rules authorized by this subsection (g) shall be
24 deemed to be necessary for the public interest, safety, and
25 welfare.

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

1 implementation of the State's fiscal year 2003 budget,
2 emergency rules to implement any provision of Public Act 92-597
3 or any other budget initiative for fiscal year 2003 may be
4 adopted in accordance with this Section by the agency charged
5 with administering that provision or initiative, except that
6 the 24-month limitation on the adoption of emergency rules and
7 the provisions of Sections 5-115 and 5-125 do not apply to
8 rules adopted under this subsection (h). The adoption of
9 emergency rules authorized by this subsection (h) shall be
10 deemed to be necessary for the public interest, safety, and
11 welfare.

12 (i) In order to provide for the expeditious and timely
13 implementation of the State's fiscal year 2004 budget,
14 emergency rules to implement any provision of Public Act 93-20
15 or any other budget initiative for fiscal year 2004 may be
16 adopted in accordance with this Section by the agency charged
17 with administering that provision or initiative, except that
18 the 24-month limitation on the adoption of emergency rules and
19 the provisions of Sections 5-115 and 5-125 do not apply to
20 rules adopted under this subsection (i). The adoption of
21 emergency rules authorized by this subsection (i) shall be
22 deemed to be necessary for the public interest, safety, and
23 welfare.

24 (j) In order to provide for the expeditious and timely
25 implementation of the provisions of the State's fiscal year
26 2005 budget as provided under the Fiscal Year 2005 Budget

1 Implementation (Human Services) Act, emergency rules to
2 implement any provision of the Fiscal Year 2005 Budget
3 Implementation (Human Services) Act may be adopted in
4 accordance with this Section by the agency charged with
5 administering that provision, except that the 24-month
6 limitation on the adoption of emergency rules and the
7 provisions of Sections 5-115 and 5-125 do not apply to rules
8 adopted under this subsection (j). The Department of Public Aid
9 may also adopt rules under this subsection (j) necessary to
10 administer the Illinois Public Aid Code and the Children's
11 Health Insurance Program Act. The adoption of emergency rules
12 authorized by this subsection (j) shall be deemed to be
13 necessary for the public interest, safety, and welfare.

14 (k) In order to provide for the expeditious and timely
15 implementation of the provisions of the State's fiscal year
16 2006 budget, emergency rules to implement any provision of
17 Public Act 94-48 or any other budget initiative for fiscal year
18 2006 may be adopted in accordance with this Section by the
19 agency charged with administering that provision or
20 initiative, except that the 24-month limitation on the adoption
21 of emergency rules and the provisions of Sections 5-115 and
22 5-125 do not apply to rules adopted under this subsection (k).
23 The Department of Healthcare and Family Services may also adopt
24 rules under this subsection (k) necessary to administer the
25 Illinois Public Aid Code, the Senior Citizens and Persons with
26 Disabilities Property Tax Relief Act, the Senior Citizens and

1 Disabled Persons Prescription Drug Discount Program Act (now
2 the Illinois Prescription Drug Discount Program Act), and the
3 Children's Health Insurance Program Act. The adoption of
4 emergency rules authorized by this subsection (k) shall be
5 deemed to be necessary for the public interest, safety, and
6 welfare.

7 (l) In order to provide for the expeditious and timely
8 implementation of the provisions of the State's fiscal year
9 2007 budget, the Department of Healthcare and Family Services
10 may adopt emergency rules during fiscal year 2007, including
11 rules effective July 1, 2007, in accordance with this
12 subsection to the extent necessary to administer the
13 Department's responsibilities with respect to amendments to
14 the State plans and Illinois waivers approved by the federal
15 Centers for Medicare and Medicaid Services necessitated by the
16 requirements of Title XIX and Title XXI of the federal Social
17 Security Act. The adoption of emergency rules authorized by
18 this subsection (l) shall be deemed to be necessary for the
19 public interest, safety, and welfare.

20 (m) In order to provide for the expeditious and timely
21 implementation of the provisions of the State's fiscal year
22 2008 budget, the Department of Healthcare and Family Services
23 may adopt emergency rules during fiscal year 2008, including
24 rules effective July 1, 2008, in accordance with this
25 subsection to the extent necessary to administer the
26 Department's responsibilities with respect to amendments to

1 the State plans and Illinois waivers approved by the federal
2 Centers for Medicare and Medicaid Services necessitated by the
3 requirements of Title XIX and Title XXI of the federal Social
4 Security Act. The adoption of emergency rules authorized by
5 this subsection (m) shall be deemed to be necessary for the
6 public interest, safety, and welfare.

7 (n) In order to provide for the expeditious and timely
8 implementation of the provisions of the State's fiscal year
9 2010 budget, emergency rules to implement any provision of
10 Public Act 96-45 or any other budget initiative authorized by
11 the 96th General Assembly for fiscal year 2010 may be adopted
12 in accordance with this Section by the agency charged with
13 administering that provision or initiative. The adoption of
14 emergency rules authorized by this subsection (n) shall be
15 deemed to be necessary for the public interest, safety, and
16 welfare. The rulemaking authority granted in this subsection
17 (n) shall apply only to rules promulgated during Fiscal Year
18 2010.

19 (o) In order to provide for the expeditious and timely
20 implementation of the provisions of the State's fiscal year
21 2011 budget, emergency rules to implement any provision of
22 Public Act 96-958 or any other budget initiative authorized by
23 the 96th General Assembly for fiscal year 2011 may be adopted
24 in accordance with this Section by the agency charged with
25 administering that provision or initiative. The adoption of
26 emergency rules authorized by this subsection (o) is deemed to

1 be necessary for the public interest, safety, and welfare. The
2 rulemaking authority granted in this subsection (o) applies
3 only to rules promulgated on or after July 1, 2010 (the
4 effective date of Public Act 96-958) through June 30, 2011.

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

18 (q) In order to provide for the expeditious and timely
19 implementation of the provisions of Articles 7, 8, 9, 11, and
20 12 of Public Act 98-104, emergency rules to implement any
21 provision of Articles 7, 8, 9, 11, and 12 of Public Act 98-104
22 may be adopted in accordance with this subsection (q) by the
23 agency charged with administering that provision or
24 initiative. The 24-month limitation on the adoption of
25 emergency rules does not apply to rules adopted under this
26 subsection (q). The adoption of emergency rules authorized by

1 this subsection (q) is deemed to be necessary for the public
2 interest, safety, and welfare.

3 (r) In order to provide for the expeditious and timely
4 implementation of the provisions of Public Act 98-651,
5 emergency rules to implement Public Act 98-651 may be adopted
6 in accordance with this subsection (r) by the Department of
7 Healthcare and Family Services. The 24-month limitation on the
8 adoption of emergency rules does not apply to rules adopted
9 under this subsection (r). The adoption of emergency rules
10 authorized by this subsection (r) is deemed to be necessary for
11 the public interest, safety, and welfare.

12 (s) In order to provide for the expeditious and timely
13 implementation of the provisions of Sections 5-5b.1 and 5A-2 of
14 the Illinois Public Aid Code, emergency rules to implement any
15 provision of Section 5-5b.1 or Section 5A-2 of the Illinois
16 Public Aid Code may be adopted in accordance with this
17 subsection (s) by the Department of Healthcare and Family
18 Services. The rulemaking authority granted in this subsection
19 (s) shall apply only to those rules adopted prior to July 1,
20 2015. Notwithstanding any other provision of this Section, any
21 emergency rule adopted under this subsection (s) shall only
22 apply to payments made for State fiscal year 2015. The adoption
23 of emergency rules authorized by this subsection (s) is deemed
24 to be necessary for the public interest, safety, and welfare.

25 (t) In order to provide for the expeditious and timely
26 implementation of the provisions of Article II of Public Act

1 99-6, emergency rules to implement the changes made by Article
2 II of Public Act 99-6 to the Emergency Telephone System Act may
3 be adopted in accordance with this subsection (t) by the
4 Department of State Police. The rulemaking authority granted in
5 this subsection (t) shall apply only to those rules adopted
6 prior to July 1, 2016. The 24-month limitation on the adoption
7 of emergency rules does not apply to rules adopted under this
8 subsection (t). The adoption of emergency rules authorized by
9 this subsection (t) is deemed to be necessary for the public
10 interest, safety, and welfare.

11 (u) In order to provide for the expeditious and timely
12 implementation of the provisions of the Burn Victims Relief
13 Act, emergency rules to implement any provision of the Act may
14 be adopted in accordance with this subsection (u) by the
15 Department of Insurance. The rulemaking authority granted in
16 this subsection (u) shall apply only to those rules adopted
17 prior to December 31, 2015. The adoption of emergency rules
18 authorized by this subsection (u) is deemed to be necessary for
19 the public interest, safety, and welfare.

20 (v) In order to provide for the expeditious and timely
21 implementation of the provisions of Public Act 99-516,
22 emergency rules to implement Public Act 99-516 may be adopted
23 in accordance with this subsection (v) by the Department of
24 Healthcare and Family Services. The 24-month limitation on the
25 adoption of emergency rules does not apply to rules adopted
26 under this subsection (v). The adoption of emergency rules

1 authorized by this subsection (v) is deemed to be necessary for
2 the public interest, safety, and welfare.

3 (w) In order to provide for the expeditious and timely
4 implementation of the provisions of Public Act 99-796,
5 emergency rules to implement the changes made by Public Act
6 99-796 may be adopted in accordance with this subsection (w) by
7 the Adjutant General. The adoption of emergency rules
8 authorized by this subsection (w) is deemed to be necessary for
9 the public interest, safety, and welfare.

10 (x) In order to provide for the expeditious and timely
11 implementation of the provisions of Public Act 99-906,
12 emergency rules to implement subsection (i) of Section 16-115D,
13 subsection (g) of Section 16-128A, and subsection (a) of
14 Section 16-128B of the Public Utilities Act may be adopted in
15 accordance with this subsection (x) by the Illinois Commerce
16 Commission. The rulemaking authority granted in this
17 subsection (x) shall apply only to those rules adopted within
18 180 days after June 1, 2017 (the effective date of Public Act
19 99-906). The adoption of emergency rules authorized by this
20 subsection (x) is deemed to be necessary for the public
21 interest, safety, and welfare.

22 (y) In order to provide for the expeditious and timely
23 implementation of the provisions of this amendatory Act of the
24 100th General Assembly, emergency rules to implement the
25 changes made by this amendatory Act of the 100th General
26 Assembly to Section 4.02 of the Illinois Act on Aging, Sections

1 5.5.4 and 5-5.4i of the Illinois Public Aid Code, Section 55-30
2 of the Alcoholism and Other Drug Abuse and Dependency Act, and
3 Sections 74 and 75 of the Mental Health and Developmental
4 Disabilities Administrative Act may be adopted in accordance
5 with this subsection (y) by the respective Department. The
6 adoption of emergency rules authorized by this subsection (y)
7 is deemed to be necessary for the public interest, safety, and
8 welfare.

9 (z) In order to provide for the expeditious and timely
10 implementation of the provisions of this amendatory Act of the
11 100th General Assembly, emergency rules to implement the
12 changes made by this amendatory Act of the 100th General
13 Assembly to Section 4.7 of the Lobbyist Registration Act may be
14 adopted in accordance with this subsection (z) by the Secretary
15 of State. The adoption of emergency rules authorized by this
16 subsection (z) is deemed to be necessary for the public
17 interest, safety, and welfare.

18 (aa) In order to provide for the expeditious and timely
19 initial implementation of the changes made to Articles 5, 5A,
20 12, and 14 of the Illinois Public Aid Code under the provisions
21 of this amendatory Act of the 100th General Assembly, the
22 Department of Healthcare and Family Services may adopt
23 emergency rules in accordance with this subsection (aa). The
24 24-month limitation on the adoption of emergency rules does not
25 apply to rules to initially implement the changes made to
26 Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code

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

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

8 (5 ILCS 100/5-46.3 new)

9 Sec. 5-46.3. Approval of rules to implement the hospital
10 transformation program. Notwithstanding any other provision of
11 this Act, the Department of Healthcare and Family Services may
12 not file, the Secretary of State may not accept, and the Joint
13 Committee on Administrative Rules may not consider any rules
14 adopted in accordance to subsection (d-5) of Section 14-12 of
15 the Illinois Public Aid Code unless the rules have been
16 approved by 9 of the 14 members of the Hospital Transformation
17 Review Committee created under subsection (d-5) of Section
18 14-12 of the Illinois Public Aid Code. Approval of the rules
19 shall be demonstrated by submission of a written document
20 signed by each of the 9 approving members. The Department of
21 Healthcare and Family Services shall submit the written
22 document with signatures, along with a certified copy of each
23 rule, to the Secretary of State.

24 Section 3. The Illinois Health Facilities Planning Act is

1 amended by changing Section 3 as follows:

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

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

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

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

6 "Health care facilities" means and includes the following
7 facilities, organizations, and related persons:

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

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

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

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

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

25 (3.5) Skilled and intermediate care facilities

1 licensed under the ID/DD Community Care Act or the MC/DD
2 Act. No permit or exemption is required for a facility
3 licensed under the ID/DD Community Care Act or the MC/DD
4 Act prior to the reduction of the number of beds at a
5 facility. If there is a total reduction of beds at a
6 facility licensed under the ID/DD Community Care Act or the
7 MC/DD Act, this is a discontinuation or closure of the
8 facility. If a facility licensed under the ID/DD Community
9 Care Act or the MC/DD Act reduces the number of beds or
10 discontinues the facility, that facility must notify the
11 Board as provided in Section 14.1 of this Act.

12 (3.7) Facilities licensed under the Specialized Mental
13 Health Rehabilitation Act of 2013.

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

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

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

25 (B) This Act does not apply to a dialysis unit
26 located in a licensed nursing home that offers or

1 provides dialysis-related services to residents with
2 end stage renal disease who have elected to receive
3 home dialysis within the nursing home.

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

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

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

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

22 "Health care facilities" does not include the following
23 entities or facility transactions:

24 (1) Federally-owned facilities.

25 (2) Facilities used solely for healing by prayer or
26 spiritual means.

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

7 (4) Facilities licensed under the Supportive
8 Residences Licensing Act or the Assisted Living and Shared
9 Housing Act.

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

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

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

1 Assisted Living and Shared Housing Act and with the
2 exception of a facility licensed under the Specialized
3 Mental Health Rehabilitation Act of 2013 in connection with
4 a proposal to close a facility and re-establish the
5 facility in another location.

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

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

1 of the dates that bed changes or service changes occur.

2 With the exception of those health care facilities
3 specifically included in this Section, nothing in this Act
4 shall be intended to include facilities operated as a part of
5 the practice of a physician or other licensed health care
6 professional, whether practicing in his individual capacity or
7 within the legal structure of any partnership, medical or
8 professional corporation, or unincorporated medical or
9 professional group. Further, this Act shall not apply to
10 physicians or other licensed health care professional's
11 practices where such practices are carried out in a portion of
12 a health care facility under contract with such health care
13 facility by a physician or by other licensed health care
14 professionals, whether practicing in his individual capacity
15 or within the legal structure of any partnership, medical or
16 professional corporation, or unincorporated medical or
17 professional groups, unless the entity constructs, modifies,
18 or establishes a health care facility as specifically defined
19 in this Section. This Act shall apply to construction or
20 modification and to establishment by such health care facility
21 of such contracted portion which is subject to facility
22 licensing requirements, irrespective of the party responsible
23 for such action or attendant financial obligation.

24 "Person" means any one or more natural persons, legal
25 entities, governmental bodies other than federal, or any
26 combination thereof.

1 "Consumer" means any person other than a person (a) whose
2 major occupation currently involves or whose official capacity
3 within the last 12 months has involved the providing,
4 administering or financing of any type of health care facility,
5 (b) who is engaged in health research or the teaching of
6 health, (c) who has a material financial interest in any
7 activity which involves the providing, administering or
8 financing of any type of health care facility, or (d) who is or
9 ever has been a member of the immediate family of the person
10 defined by (a), (b), or (c).

11 "State Board" or "Board" means the Health Facilities and
12 Services Review Board.

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

1 this Act.

2 "Establish" means the construction of a health care
3 facility or the replacement of an existing facility on another
4 site or the initiation of a category of service.

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

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

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

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

1 capital expenditures.

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

21 "Areawide" means a major area of the State delineated on a
22 geographic, demographic, and functional basis for health
23 planning and for health service and having within it one or
24 more local areas for health planning and health service. The
25 term "region", as contrasted with the term "subregion", and the
26 word "area" may be used synonymously with the term "areawide".

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

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

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

10 "Director" means the Director of the Illinois Department of
11 Public Health.

12 "Agency" or "Department" means the Illinois Department of
13 Public Health.

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

16 "Out-of-state facility" means a person that is both (i)
17 licensed as a hospital or as an ambulatory surgery center under
18 the laws of another state or that qualifies as a hospital or an
19 ambulatory surgery center under regulations adopted pursuant
20 to the Social Security Act and (ii) not licensed under the
21 Ambulatory Surgical Treatment Center Act, the Hospital
22 Licensing Act, or the Nursing Home Care Act. Affiliates of
23 out-of-state facilities shall be considered out-of-state
24 facilities. Affiliates of Illinois licensed health care
25 facilities 100% owned by an Illinois licensed health care
26 facility, its parent, or Illinois physicians licensed to

1 practice medicine in all its branches shall not be considered
2 out-of-state facilities. Nothing in this definition shall be
3 construed to include an office or any part of an office of a
4 physician licensed to practice medicine in all its branches in
5 Illinois that is not required to be licensed under the
6 Ambulatory Surgical Treatment Center Act.

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

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

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

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

24 "Category of service" means a grouping by generic class of
25 various types or levels of support functions, equipment, care,
26 or treatment provided to patients or residents, including, but

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

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

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

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

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

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

21 "Health care facilities" means and includes the following
22 facilities, organizations, and related persons:

23 (1) An ambulatory surgical treatment center required
24 to be licensed pursuant to the Ambulatory Surgical
25 Treatment Center Act.

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

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

6 (A) If a demonstration project under the Nursing
7 Home Care Act applies for a certificate of need to
8 convert to a nursing facility, it shall meet the
9 licensure and certificate of need requirements in
10 effect as of the date of application.

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

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

1 (3.7) Facilities licensed under the Specialized Mental
2 Health Rehabilitation Act of 2013.

3 (4) Hospitals, nursing homes, ambulatory surgical
4 treatment centers, or kidney disease treatment centers
5 maintained by the State or any department or agency
6 thereof.

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

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

14 (B) This Act does not apply to a dialysis unit
15 located in a licensed nursing home that offers or
16 provides dialysis-related services to residents with
17 end stage renal disease who have elected to receive
18 home dialysis within the nursing home.

19 (C) The Board, however, may require dialysis
20 facilities and licensed nursing homes under items (A)
21 and (B) of this subsection to report statistical
22 information on a quarterly basis to the Board to be
23 used by the Board to conduct analyses on the need for
24 proposed kidney disease treatment centers.

25 (6) An institution, place, building, or room used for
26 the performance of outpatient surgical procedures that is

1 leased, owned, or operated by or on behalf of an
2 out-of-state facility.

3 (7) An institution, place, building, or room used for
4 provision of a health care category of service, including,
5 but not limited to, cardiac catheterization and open heart
6 surgery.

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

11 "Health care facilities" does not include the following
12 entities or facility transactions:

13 (1) Federally-owned facilities.

14 (2) Facilities used solely for healing by prayer or
15 spiritual means.

16 (3) An existing facility located on any campus facility
17 as defined in Section 5-5.8b of the Illinois Public Aid
18 Code, provided that the campus facility encompasses 30 or
19 more contiguous acres and that the new or renovated
20 facility is intended for use by a licensed residential
21 facility.

22 (4) Facilities licensed under the Supportive
23 Residences Licensing Act or the Assisted Living and Shared
24 Housing Act.

25 (5) Facilities designated as supportive living
26 facilities that are in good standing with the program

1 established under Section 5-5.01a of the Illinois Public
2 Aid Code.

3 (6) Facilities established and operating under the
4 Alternative Health Care Delivery Act as a children's
5 community-based health care center alternative health care
6 model demonstration program or as an Alzheimer's Disease
7 Management Center alternative health care model
8 demonstration program.

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

21 (8) Any change of ownership of a health care facility
22 that is licensed under the Nursing Home Care Act, the
23 Specialized Mental Health Rehabilitation Act of 2013, the
24 ID/DD Community Care Act, or the MC/DD Act, with the
25 exception of facilities operated by a county or Illinois
26 Veterans Homes. Changes of ownership of facilities

1 licensed under the Nursing Home Care Act must meet the
2 requirements set forth in Sections 3-101 through 3-119 of
3 the Nursing Home Care Act.

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

17 With the exception of those health care facilities
18 specifically included in this Section, nothing in this Act
19 shall be intended to include facilities operated as a part of
20 the practice of a physician or other licensed health care
21 professional, whether practicing in his individual capacity or
22 within the legal structure of any partnership, medical or
23 professional corporation, or unincorporated medical or
24 professional group. Further, this Act shall not apply to
25 physicians or other licensed health care professional's
26 practices where such practices are carried out in a portion of

1 a health care facility under contract with such health care
2 facility by a physician or by other licensed health care
3 professionals, whether practicing in his individual capacity
4 or within the legal structure of any partnership, medical or
5 professional corporation, or unincorporated medical or
6 professional groups, unless the entity constructs, modifies,
7 or establishes a health care facility as specifically defined
8 in this Section. This Act shall apply to construction or
9 modification and to establishment by such health care facility
10 of such contracted portion which is subject to facility
11 licensing requirements, irrespective of the party responsible
12 for such action or attendant financial obligation.

13 "Person" means any one or more natural persons, legal
14 entities, governmental bodies other than federal, or any
15 combination thereof.

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

26 "State Board" or "Board" means the Health Facilities and

1 Services Review Board.

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

17 "Establish" means the construction of a health care
18 facility or the replacement of an existing facility on another
19 site or the initiation of a category of service.

20 "Major medical equipment" means medical equipment which is
21 used for the provision of medical and other health services and
22 which costs in excess of the capital expenditure minimum,
23 except that such term does not include medical equipment
24 acquired by or on behalf of a clinical laboratory to provide
25 clinical laboratory services if the clinical laboratory is
26 independent of a physician's office and a hospital and it has

1 been determined under Title XVIII of the Social Security Act to
2 meet the requirements of paragraphs (10) and (11) of Section
3 1861(s) of such Act. In determining whether medical equipment
4 has a value in excess of the capital expenditure minimum, the
5 value of studies, surveys, designs, plans, working drawings,
6 specifications, and other activities essential to the
7 acquisition of such equipment shall be included.

8 "Capital Expenditure" means an expenditure: (A) made by or
9 on behalf of a health care facility (as such a facility is
10 defined in this Act); and (B) which under generally accepted
11 accounting principles is not properly chargeable as an expense
12 of operation and maintenance, or is made to obtain by lease or
13 comparable arrangement any facility or part thereof or any
14 equipment for a facility or part; and which exceeds the capital
15 expenditure minimum.

16 For the purpose of this paragraph, the cost of any studies,
17 surveys, designs, plans, working drawings, specifications, and
18 other activities essential to the acquisition, improvement,
19 expansion, or replacement of any plant or equipment with
20 respect to which an expenditure is made shall be included in
21 determining if such expenditure exceeds the capital
22 expenditures minimum. Unless otherwise interdependent, or
23 submitted as one project by the applicant, components of
24 construction or modification undertaken by means of a single
25 construction contract or financed through the issuance of a
26 single debt instrument shall not be grouped together as one

1 project. Donations of equipment or facilities to a health care
2 facility which if acquired directly by such facility would be
3 subject to review under this Act shall be considered capital
4 expenditures, and a transfer of equipment or facilities for
5 less than fair market value shall be considered a capital
6 expenditure for purposes of this Act if a transfer of the
7 equipment or facilities at fair market value would be subject
8 to review.

9 "Capital expenditure minimum" means \$11,500,000 for
10 projects by hospital applicants, \$6,500,000 for applicants for
11 projects related to skilled and intermediate care long-term
12 care facilities licensed under the Nursing Home Care Act, and
13 \$3,000,000 for projects by all other applicants, which shall be
14 annually adjusted to reflect the increase in construction costs
15 due to inflation, for major medical equipment and for all other
16 capital expenditures.

17 "Financial Commitment" means the commitment of at least 33%
18 of total funds assigned to cover total project cost, which
19 occurs by the actual expenditure of 33% or more of the total
20 project cost or the commitment to expend 33% or more of the
21 total project cost by signed contracts or other legal means.

22 "Non-clinical service area" means an area (i) for the
23 benefit of the patients, visitors, staff, or employees of a
24 health care facility and (ii) not directly related to the
25 diagnosis, treatment, or rehabilitation of persons receiving
26 services from the health care facility. "Non-clinical service

1 areas" include, but are not limited to, chapels; gift shops;
2 news stands; computer systems; tunnels, walkways, and
3 elevators; telephone systems; projects to comply with life
4 safety codes; educational facilities; student housing;
5 patient, employee, staff, and visitor dining areas;
6 administration and volunteer offices; modernization of
7 structural components (such as roof replacement and masonry
8 work); boiler repair or replacement; vehicle maintenance and
9 storage facilities; parking facilities; mechanical systems for
10 heating, ventilation, and air conditioning; loading docks; and
11 repair or replacement of carpeting, tile, wall coverings,
12 window coverings or treatments, or furniture. Solely for the
13 purpose of this definition, "non-clinical service area" does
14 not include health and fitness centers.

15 "Areawide" means a major area of the State delineated on a
16 geographic, demographic, and functional basis for health
17 planning and for health service and having within it one or
18 more local areas for health planning and health service. The
19 term "region", as contrasted with the term "subregion", and the
20 word "area" may be used synonymously with the term "areawide".

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

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

1 "Licensed health care professional" means a person
2 licensed to practice a health profession under pertinent
3 licensing statutes of the State of Illinois.

4 "Director" means the Director of the Illinois Department of
5 Public Health.

6 "Agency" or "Department" means the Illinois Department of
7 Public Health.

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

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

1 "Change of ownership of a health care facility" means a
2 change in the person who has ownership or control of a health
3 care facility's physical plant and capital assets. A change in
4 ownership is indicated by the following transactions: sale,
5 transfer, acquisition, lease, change of sponsorship, or other
6 means of transferring control.

7 "Related person" means any person that: (i) is at least 50%
8 owned, directly or indirectly, by either the health care
9 facility or a person owning, directly or indirectly, at least
10 50% of the health care facility; or (ii) owns, directly or
11 indirectly, at least 50% of the health care facility.

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

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

18 "Category of service" means a grouping by generic class of
19 various types or levels of support functions, equipment, care,
20 or treatment provided to patients or residents, including, but
21 not limited to, classes such as medical-surgical, pediatrics,
22 or cardiac catheterization. A category of service may include
23 subcategories or levels of care that identify a particular
24 degree or type of care within the category of service. Nothing
25 in this definition shall be construed to include the practice
26 of a physician or other licensed health care professional while

1 functioning in an office providing for the care, diagnosis, or
2 treatment of patients. A category of service that is subject to
3 the Board's jurisdiction must be designated in rules adopted by
4 the Board.

5 "State Board Staff Report" means the document that sets
6 forth the review and findings of the State Board staff, as
7 prescribed by the State Board, regarding applications subject
8 to Board jurisdiction.

9 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
10 99-527, eff. 1-1-17; 100-518, eff. 6-1-18.)

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

13 (210 ILCS 50/32.5)

14 Sec. 32.5. Freestanding Emergency Center.

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

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

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

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

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

8 (B) equipment standards; and

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

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

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

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

26 (7) (blank);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 subject to the hospital's transformation under subsection
2 (d-5) of Section 14-12 of the Illinois Public Aid Code; and
3 (4) the facility is located at the same physical
4 location where the facility served as a hospital.

5 (b) The Department shall:

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

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

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

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

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

25 Section 15. The Illinois Public Aid Code is amended by

1 changing Sections 5-5.02, 5-5e.1, 5A-2, 5A-4, 5A-5, 5A-8,
2 5A-10, 5A-12.5, 5A-13, 5A-14, 5A-15, 12-4.105, and 14-12, and
3 by adding Sections 5A-12.6, and 5A-16 as follows:

4 (305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

5 Sec. 5-5.02. Hospital reimbursements.

6 (a) Reimbursement to Hospitals; July 1, 1992 through
7 September 30, 1992. Notwithstanding any other provisions of
8 this Code or the Illinois Department's Rules promulgated under
9 the Illinois Administrative Procedure Act, reimbursement to
10 hospitals for services provided during the period July 1, 1992
11 through September 30, 1992, shall be as follows:

12 (1) For inpatient hospital services rendered, or if
13 applicable, for inpatient hospital discharges occurring,
14 on or after July 1, 1992 and on or before September 30,
15 1992, the Illinois Department shall reimburse hospitals
16 for inpatient services under the reimbursement
17 methodologies in effect for each hospital, and at the
18 inpatient payment rate calculated for each hospital, as of
19 June 30, 1992. For purposes of this paragraph,
20 "reimbursement methodologies" means all reimbursement
21 methodologies that pertain to the provision of inpatient
22 hospital services, including, but not limited to, any
23 adjustments for disproportionate share, targeted access,
24 critical care access and uncompensated care, as defined by
25 the Illinois Department on June 30, 1992.

1 (2) For the purpose of calculating the inpatient
2 payment rate for each hospital eligible to receive
3 quarterly adjustment payments for targeted access and
4 critical care, as defined by the Illinois Department on
5 June 30, 1992, the adjustment payment for the period July
6 1, 1992 through September 30, 1992, shall be 25% of the
7 annual adjustment payments calculated for each eligible
8 hospital, as of June 30, 1992. The Illinois Department
9 shall determine by rule the adjustment payments for
10 targeted access and critical care beginning October 1,
11 1992.

12 (3) For the purpose of calculating the inpatient
13 payment rate for each hospital eligible to receive
14 quarterly adjustment payments for uncompensated care, as
15 defined by the Illinois Department on June 30, 1992, the
16 adjustment payment for the period August 1, 1992 through
17 September 30, 1992, shall be one-sixth of the total
18 uncompensated care adjustment payments calculated for each
19 eligible hospital for the uncompensated care rate year, as
20 defined by the Illinois Department, ending on July 31,
21 1992. The Illinois Department shall determine by rule the
22 adjustment payments for uncompensated care beginning
23 October 1, 1992.

24 (b) Inpatient payments. For inpatient services provided on
25 or after October 1, 1993, in addition to rates paid for
26 hospital inpatient services pursuant to the Illinois Health

1 Finance Reform Act, as now or hereafter amended, or the
2 Illinois Department's prospective reimbursement methodology,
3 or any other methodology used by the Illinois Department for
4 inpatient services, the Illinois Department shall make
5 adjustment payments, in an amount calculated pursuant to the
6 methodology described in paragraph (c) of this Section, to
7 hospitals that the Illinois Department determines satisfy any
8 one of the following requirements:

9 (1) Hospitals that are described in Section 1923 of the
10 federal Social Security Act, as now or hereafter amended,
11 except that for rate year 2015 and after a hospital
12 described in Section 1923(b)(1)(B) of the federal Social
13 Security Act and qualified for the payments described in
14 subsection (c) of this Section for rate year 2014 provided
15 the hospital continues to meet the description in Section
16 1923(b)(1)(B) in the current determination year; or

17 (2) Illinois hospitals that have a Medicaid inpatient
18 utilization rate which is at least one-half a standard
19 deviation above the mean Medicaid inpatient utilization
20 rate for all hospitals in Illinois receiving Medicaid
21 payments from the Illinois Department; or

22 (3) Illinois hospitals that on July 1, 1991 had a
23 Medicaid inpatient utilization rate, as defined in
24 paragraph (h) of this Section, that was at least the mean
25 Medicaid inpatient utilization rate for all hospitals in
26 Illinois receiving Medicaid payments from the Illinois

1 Department and which were located in a planning area with
2 one-third or fewer excess beds as determined by the Health
3 Facilities and Services Review Board, and that, as of June
4 30, 1992, were located in a federally designated Health
5 Manpower Shortage Area; or

6 (4) Illinois hospitals that:

7 (A) have a Medicaid inpatient utilization rate
8 that is at least equal to the mean Medicaid inpatient
9 utilization rate for all hospitals in Illinois
10 receiving Medicaid payments from the Department; and

11 (B) also have a Medicaid obstetrical inpatient
12 utilization rate that is at least one standard
13 deviation above the mean Medicaid obstetrical
14 inpatient utilization rate for all hospitals in
15 Illinois receiving Medicaid payments from the
16 Department for obstetrical services; or

17 (5) Any children's hospital, which means a hospital
18 devoted exclusively to caring for children. A hospital
19 which includes a facility devoted exclusively to caring for
20 children shall be considered a children's hospital to the
21 degree that the hospital's Medicaid care is provided to
22 children if either (i) the facility devoted exclusively to
23 caring for children is separately licensed as a hospital by
24 a municipality prior to February 28, 2013 or (ii) the
25 hospital has been designated by the State as a Level III
26 perinatal care facility, has a Medicaid Inpatient

1 Utilization rate greater than 55% for the rate year 2003
2 disproportionate share determination, and has more than
3 10,000 qualified children days as defined by the Department
4 in rulemaking.

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

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

11 (2) hospitals with a Medicaid inpatient utilization
12 rate that is equal to or greater than the mean Medicaid
13 inpatient utilization rate but less than one standard
14 deviation above the mean Medicaid inpatient utilization
15 rate shall receive a per day adjustment payment equal to
16 the sum of \$25 plus \$1 for each one percent that the
17 hospital's Medicaid inpatient utilization rate exceeds the
18 mean Medicaid inpatient utilization rate;

19 (3) hospitals with a Medicaid inpatient utilization
20 rate that is equal to or greater than one standard
21 deviation above the mean Medicaid inpatient utilization
22 rate but less than 1.5 standard deviations above the mean
23 Medicaid inpatient utilization rate shall receive a per day
24 adjustment payment equal to the sum of \$40 plus \$7 for each
25 one percent that the hospital's Medicaid inpatient
26 utilization rate exceeds one standard deviation above the

1 mean Medicaid inpatient utilization rate; and

2 (4) hospitals with a Medicaid inpatient utilization
3 rate that is equal to or greater than 1.5 standard
4 deviations above the mean Medicaid inpatient utilization
5 rate shall receive a per day adjustment payment equal to
6 the sum of \$90 plus \$2 for each one percent that the
7 hospital's Medicaid inpatient utilization rate exceeds 1.5
8 standard deviations above the mean Medicaid inpatient
9 utilization rate.

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

20 (e) The inpatient adjustment payments described in
21 paragraphs (c) and (d) shall be increased on October 1, 1993
22 and annually thereafter by a percentage equal to the lesser of
23 (i) the increase in the DRI hospital cost index for the most
24 recent 12 month period for which data are available, or (ii)
25 the percentage increase in the statewide average hospital
26 payment rate over the previous year's statewide average

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

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

17 (g) County hospital inpatient adjustment payments. For
18 county hospitals, as defined in subsection (c) of Section 15-1
19 of this Code, there shall be an adjustment payment as
20 determined by rules issued by the Illinois Department.

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

23 (1) "Medicaid inpatient utilization rate" means a
24 fraction, the numerator of which is the number of a
25 hospital's inpatient days provided in a given 12-month
26 period to patients who, for such days, were eligible for

1 Medicaid under Title XIX of the federal Social Security
2 Act, and the denominator of which is the total number of
3 the hospital's inpatient days in that same period.

4 (2) "Mean Medicaid inpatient utilization rate" means
5 the total number of Medicaid inpatient days provided by all
6 Illinois Medicaid-participating hospitals divided by the
7 total number of inpatient days provided by those same
8 hospitals.

9 (3) "Medicaid obstetrical inpatient utilization rate"
10 means the ratio of Medicaid obstetrical inpatient days to
11 total Medicaid inpatient days for all Illinois hospitals
12 receiving Medicaid payments from the Illinois Department.

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

17 (j) University of Illinois Hospital inpatient adjustment
18 payments. For hospitals organized under the University of
19 Illinois Hospital Act, there shall be an adjustment payment as
20 determined by rules adopted by the Illinois Department.

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

24 (l) On and after July 1, 2012, the Department shall reduce
25 any rate of reimbursement for services or other payments or
26 alter any methodologies authorized by this Code to reduce any

1 rate of reimbursement for services or other payments in
2 accordance with Section 5-5e.

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

7 (1) As used in this subsection, "hospitals" means the
8 University of Illinois Hospital as defined in the
9 University of Illinois Hospital Act and a county hospital
10 in a county of over 3,000,000 inhabitants.

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

15 (A) inpatient days;

16 (B) outpatient days;

17 (C) direct costs;

18 (D) indirect costs;

19 (E) managed care days;

20 (F) all stages of medical training and education
21 including students, interns, residents, and fellows
22 with no caps on the number of persons who may qualify;
23 and

24 (G) patient care payments related to the
25 complexities of treating Medicaid enrollees including
26 clinical and social determinants of health.

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

4 (4) The Department shall promptly take all actions
5 necessary for reimbursement to be effective for dates of
6 service on and after July 1, 2018 including publishing all
7 appropriate public notices, amendments to the Illinois
8 Title XIX State Plan, and adoption of administrative rules
9 if necessary.

10 (5) As used in this subsection, "managed care days"
11 means costs associated with services rendered to enrollees
12 of Medicaid managed care entities. "Medicaid managed care
13 entities" means any entity which contracts with the
14 Department to provide services paid for on a capitated
15 basis. "Medicaid managed care entities" includes a managed
16 care organization and a managed care community network.

17 (6) All payments under this Section are contingent upon
18 federal approval of changes to the Illinois Title XIX State
19 Plan, if that approval is required.

20 (7) The Department may adopt rules necessary to
21 implement this amendatory Act of the 100th General Assembly
22 through the use of emergency rulemaking in accordance with
23 subsection (aa) of Section 5-45 of the Illinois
24 Administrative Procedure Act. For purposes of that Act, the
25 General Assembly finds that the adoption of rules to
26 implement this amendatory Act of the 100th General Assembly

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

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

4 (305 ILCS 5/5-5e.1)

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

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

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

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

12 (3) meets one of the following:

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

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

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

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

22 (2) "MIUR" means Medicaid Inpatient Utilization Rate
23 and is defined as a fraction, the numerator of which is the
24 number of a hospital's inpatient days provided in the
25 hospital's fiscal year ending 3 years prior to the rate

1 year, to patients who, for such days, were eligible for
2 Medicaid under Title XIX of the federal Social Security
3 Act, 42 USC 1396a et seq., excluding those persons eligible
4 for medical assistance pursuant to 42 U.S.C.
5 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
6 Section 5-2 of this Article, and the denominator of which
7 is the total number of the hospital's inpatient days in
8 that same period, excluding those persons eligible for
9 medical assistance pursuant to 42 U.S.C.
10 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
11 Section 5-2 of this Article.

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

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

16 (c) Beginning July 1, 2012 and ending on June 30, 2020
17 ~~2018~~, a hospital that would have qualified for the rate year
18 beginning October 1, 2011, shall be a Safety-Net Hospital.

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

23 (e) The Department may promulgate rules in order to
24 implement this Section.

25 (f) Nothing in this Section shall be construed as limiting
26 the ability of the Department to include the Safety-Net

1 Hospitals in the hospital rate reform mandated by Section 14-11
2 of this Code and implemented under Section 14-12 of this Code
3 and by administrative rulemaking.

4 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;
5 98-651, eff. 6-16-14.)

6 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

8 Sec. 5A-2. Assessment.

9 (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal
10 years 2009 through 2018, or as long as continued under Section
11 5A-16, an annual assessment on inpatient services is imposed on
12 each hospital provider in an amount equal to \$218.38 multiplied
13 by the difference of the hospital's occupied bed days less the
14 hospital's Medicare bed days, provided, however, that the
15 amount of \$218.38 shall be increased by a uniform percentage to
16 generate an amount equal to 75% of the State share of the
17 payments authorized under Section 5A-12.5, with such increase
18 only taking effect upon the date that a State share for such
19 payments is required under federal law. For the period of April
20 through June 2015, the amount of \$218.38 used to calculate the
21 assessment under this paragraph shall, by emergency rule under
22 subsection (s) of Section 5-45 of the Illinois Administrative
23 Procedure Act, be increased by a uniform percentage to generate
24 \$20,250,000 in the aggregate for that period from all hospitals
25 subject to the annual assessment under this paragraph.

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

9 For State fiscal years 2009 through 2018 ~~2014 and after,~~ or
10 as provided in Section 5A-16, a hospital's occupied bed days
11 and Medicare bed days shall be determined using the most recent
12 data available from each hospital's 2005 Medicare cost report
13 as contained in the Healthcare Cost Report Information System
14 file, for the quarter ending on December 31, 2006, without
15 regard to any subsequent adjustments or changes to such data.
16 If a hospital's 2005 Medicare cost report is not contained in
17 the Healthcare Cost Report Information System, then the
18 Illinois Department may obtain the hospital provider's
19 occupied bed days and Medicare bed days from any source
20 available, including, but not limited to, records maintained by
21 the hospital provider, which may be inspected at all times
22 during business hours of the day by the Illinois Department or
23 its duly authorized agents and employees.

24 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
25 fiscal years 2019 and 2020, an annual assessment on inpatient
26 services is imposed on each hospital provider in an amount

1 equal to \$197.19 multiplied by the difference of the hospital's
2 occupied bed days less the hospital's Medicare bed days;
3 however, for State fiscal year 2020, the amount of \$197.19
4 shall be increased by a uniform percentage to generate an
5 additional \$6,250,000 in the aggregate for that period from all
6 hospitals subject to the annual assessment under this
7 paragraph. For State fiscal years 2019 and 2020, a hospital's
8 occupied bed days and Medicare bed days shall be determined
9 using the most recent data available from each hospital's 2015
10 Medicare cost report as contained in the Healthcare Cost Report
11 Information System file, for the quarter ending on March 31,
12 2017, without regard to any subsequent adjustments or changes
13 to such data. If a hospital's 2015 Medicare cost report is not
14 contained in the Healthcare Cost Report Information System,
15 then the Illinois Department may obtain the hospital provider's
16 occupied bed days and Medicare bed days from any source
17 available, including, but not limited to, records maintained by
18 the hospital provider, which may be inspected at all times
19 during business hours of the day by the Illinois Department or
20 its duly authorized agents and employees. Notwithstanding any
21 other provision in this Article, for a hospital provider that
22 did not have a 2015 Medicare cost report, but paid an
23 assessment in State fiscal year 2018 on the basis of
24 hypothetical data, that assessment amount shall be used for
25 State fiscal years 2019 and 2020; however, for State fiscal
26 year 2020, the assessment amount shall be increased by the

1 proportion that it represents of the total annual assessment
2 that is generated from all hospitals in order to generate
3 \$6,250,000 in the aggregate for that period from all hospitals
4 subject to the annual assessment under this paragraph.

5 Subject to Sections 5A-3 and 5A-10, for State fiscal years
6 2021 through 2024, an annual assessment on inpatient services
7 is imposed on each hospital provider in an amount equal to
8 \$197.19 multiplied by the difference of the hospital's occupied
9 bed days less the hospital's Medicare bed days, provided
10 however, that the amount of \$197.19 used to calculate the
11 assessment under this paragraph shall, by rule, be adjusted by
12 a uniform percentage to generate the same total annual
13 assessment that was generated in State fiscal year 2020 from
14 all hospitals subject to the annual assessment under this
15 paragraph plus \$6,250,000. For State fiscal years 2021 and
16 2022, a hospital's occupied bed days and Medicare bed days
17 shall be determined using the most recent data available from
18 each hospital's 2017 Medicare cost report as contained in the
19 Healthcare Cost Report Information System file, for the quarter
20 ending on March 31, 2019, without regard to any subsequent
21 adjustments or changes to such data. For State fiscal years
22 2023 and 2024, a hospital's occupied bed days and Medicare bed
23 days shall be determined using the most recent data available
24 from each hospital's 2019 Medicare cost report as contained in
25 the Healthcare Cost Report Information System file, for the
26 quarter ending on March 31, 2021, without regard to any

1 subsequent adjustments or changes to such data.

2 (b) (Blank).

3 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the
4 portion of State fiscal year 2012, beginning June 10, 2012
5 through June 30, 2012, and for State fiscal years 2013 through
6 2018, or as provided in Section 5A-16, an annual assessment on
7 outpatient services is imposed on each hospital provider in an
8 amount equal to .008766 multiplied by the hospital's outpatient
9 gross revenue, provided, however, that the amount of .008766
10 shall be increased by a uniform percentage to generate an
11 amount equal to 25% of the State share of the payments
12 authorized under Section 5A-12.5, with such increase only
13 taking effect upon the date that a State share for such
14 payments is required under federal law. For the period
15 beginning June 10, 2012 through June 30, 2012, the annual
16 assessment on outpatient services shall be prorated by
17 multiplying the assessment amount by a fraction, the numerator
18 of which is 21 days and the denominator of which is 365 days.
19 For the period of April through June 2015, the amount of
20 .008766 used to calculate the assessment under this paragraph
21 shall, by emergency rule under subsection (s) of Section 5-45
22 of the Illinois Administrative Procedure Act, be increased by a
23 uniform percentage to generate \$6,750,000 in the aggregate for
24 that period from all hospitals subject to the annual assessment
25 under this paragraph.

26 (2) In addition to any other assessments imposed under this

1 Article, effective July 1, 2016 and semi-annually thereafter
2 through June 2018, in addition to any federally required State
3 share as authorized under paragraph (1), the amount of .008766
4 shall be increased by a uniform percentage to generate an
5 amount equal to 25% of the ACA Assessment Adjustment, as
6 defined in subsection (b-6) of this Section.

7 For the portion of State fiscal year 2012, beginning June
8 10, 2012 through June 30, 2012, and State fiscal years 2013
9 through 2018, or as provided in Section 5A-16, a hospital's
10 outpatient gross revenue shall be determined using the most
11 recent data available from each hospital's 2009 Medicare cost
12 report as contained in the Healthcare Cost Report Information
13 System file, for the quarter ending on June 30, 2011, without
14 regard to any subsequent adjustments or changes to such data.
15 If a hospital's 2009 Medicare cost report is not contained in
16 the Healthcare Cost Report Information System, then the
17 Department may obtain the hospital provider's outpatient gross
18 revenue from any source available, including, but not limited
19 to, records maintained by the hospital provider, which may be
20 inspected at all times during business hours of the day by the
21 Department or its duly authorized agents and employees.

22 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
23 fiscal years 2019 and 2020, an annual assessment on outpatient
24 services is imposed on each hospital provider in an amount
25 equal to .01358 multiplied by the hospital's outpatient gross
26 revenue; however, for State fiscal year 2020, the amount of

1 .01358 shall be increased by a uniform percentage to generate
2 an additional \$6,250,000 in the aggregate for that period from
3 all hospitals subject to the annual assessment under this
4 paragraph. For State fiscal years 2019 and 2020, a hospital's
5 outpatient gross revenue shall be determined using the most
6 recent data available from each hospital's 2015 Medicare cost
7 report as contained in the Healthcare Cost Report Information
8 System file, for the quarter ending on March 31, 2017, without
9 regard to any subsequent adjustments or changes to such data.
10 If a hospital's 2015 Medicare cost report is not contained in
11 the Healthcare Cost Report Information System, then the
12 Department may obtain the hospital provider's outpatient gross
13 revenue from any source available, including, but not limited
14 to, records maintained by the hospital provider, which may be
15 inspected at all times during business hours of the day by the
16 Department or its duly authorized agents and employees.
17 Notwithstanding any other provision in this Article, for a
18 hospital provider that did not have a 2015 Medicare cost
19 report, but paid an assessment in State fiscal year 2018 on the
20 basis of hypothetical data, that assessment amount shall be
21 used for State fiscal years 2019 and 2020; however, for State
22 fiscal year 2020, the assessment amount shall be increased by
23 the proportion that it represents of the total annual
24 assessment that is generated from all hospitals in order to
25 generate \$6,250,000 in the aggregate for that period from all
26 hospitals subject to the annual assessment under this

1 paragraph.

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

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

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

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

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

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

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

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

16 (i) the amount calculated under this subparagraph

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

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

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

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

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

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

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

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

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

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

14 (c) (Blank).

15 (d) Notwithstanding any of the other provisions of this
16 Section, the Department is authorized to adopt rules to reduce
17 the rate of any annual assessment imposed under this Section,
18 as authorized by Section 5-46.2 of the Illinois Administrative
19 Procedure Act.

20 (e) Notwithstanding any other provision of this Section,
21 any plan providing for an assessment on a hospital provider as
22 a permissible tax under Title XIX of the federal Social
23 Security Act and Medicaid-eligible payments to hospital
24 providers from the revenues derived from that assessment shall
25 be reviewed by the Illinois Department of Healthcare and Family
26 Services, as the Single State Medicaid Agency required by

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

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

21 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

23 (a) The assessment imposed by Section 5A-2 for State fiscal
24 year 2009 through State fiscal year 2018 or as provided in
25 Section 5A-16, ~~and each subsequent State fiscal year shall be~~

1 due and payable in monthly installments, each equaling
2 one-twelfth of the assessment for the year, on the fourteenth
3 State business day of each month. No installment payment of an
4 assessment imposed by Section 5A-2 shall be due and payable,
5 however, until after the Comptroller has issued the payments
6 required under this Article.

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

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

8 Except as provided in subsection (a-5) of this Section, the
9 assessment imposed under Section 5A-2 for State fiscal year
10 2019 and each subsequent State fiscal year shall be due and
11 payable in monthly installments, each equaling one-twelfth of
12 the assessment for the year, on the 14th State business day of
13 each month. No installment payment of an assessment imposed by
14 Section 5A-2 shall be due and payable, however, until after:
15 (i) the Department notifies the hospital provider, in writing,
16 that the payment methodologies to hospitals required under
17 Section 5A-12.6 have been approved by the Centers for Medicare
18 and Medicaid Services of the U.S. Department of Health and
19 Human Services, and the waiver under 42 CFR 433.68 for the
20 assessment imposed by Section 5A-2, if necessary, has been
21 granted by the Centers for Medicare and Medicaid Services of
22 the U.S. Department of Health and Human Services; and (ii) the
23 Comptroller has issued the payments required under Section
24 5A-12.6. Upon notification to the Department of approval of the
25 payment methodologies required under Section 5A-12.6 and the
26 waiver granted under 42 CFR 433.68, if necessary, all

1 installments otherwise due under Section 5A-2 prior to the date
2 of notification shall be due and payable to the Department upon
3 written direction from the Department and issuance by the
4 Comptroller of the payments required under Section 5A-12.6.

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

18 (b) The Illinois Department is authorized to establish
19 delayed payment schedules for hospital providers that are
20 unable to make installment payments when due under this Section
21 due to financial difficulties, as determined by the Illinois
22 Department.

23 (c) If a hospital provider fails to pay the full amount of
24 an installment when due (including any extensions granted under
25 subsection (b)), there shall, unless waived by the Illinois
26 Department for reasonable cause, be added to the assessment

1 imposed by Section 5A-2 a penalty assessment equal to the
2 lesser of (i) 5% of the amount of the installment not paid on
3 or before the due date plus 5% of the portion thereof remaining
4 unpaid on the last day of each 30-day period thereafter or (ii)
5 100% of the installment amount not paid on or before the due
6 date. For purposes of this subsection, payments will be
7 credited first to unpaid installment amounts (rather than to
8 penalty or interest), beginning with the most delinquent
9 installments.

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

17 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;
18 98-104, eff. 7-22-13.)

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

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

21 (a) The Illinois Department shall send a notice of
22 assessment to every hospital provider subject to assessment
23 under this Article. The notice of assessment shall notify the
24 hospital of its assessment and shall be sent after receipt by
25 the Department of notification from the Centers for Medicare

1 and Medicaid Services of the U.S. Department of Health and
2 Human Services that the payment methodologies required under
3 this Article and, if necessary, the waiver granted under 42 CFR
4 433.68 have been approved. The notice shall be on a form
5 prepared by the Illinois Department and shall state the
6 following:

7 (1) The name of the hospital provider.

8 (2) The address of the hospital provider's principal
9 place of business from which the provider engages in the
10 occupation of hospital provider in this State, and the name
11 and address of each hospital operated, conducted, or
12 maintained by the provider in this State.

13 (3) The occupied bed days, occupied bed days less
14 Medicare days, adjusted gross hospital revenue, or
15 outpatient gross revenue of the hospital provider
16 (whichever is applicable), the amount of assessment
17 imposed under Section 5A-2 for the State fiscal year for
18 which the notice is sent, and the amount of each
19 installment to be paid during the State fiscal year.

20 (4) (Blank).

21 (5) Other reasonable information as determined by the
22 Illinois Department.

23 (b) If a hospital provider conducts, operates, or maintains
24 more than one hospital licensed by the Illinois Department of
25 Public Health, the provider shall pay the assessment for each
26 hospital separately.

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

13 (d) Notwithstanding any other provision in this Article, a
14 provider who commences conducting, operating, or maintaining a
15 hospital, upon notice by the Illinois Department, shall pay the
16 assessment computed under Section 5A-2 and subsection (e) in
17 installments on the due dates stated in the notice and on the
18 regular installment due dates for the State fiscal year
19 occurring after the due dates of the initial notice.

20 (e) Notwithstanding any other provision in this Article,
21 for State fiscal years 2009 through 2018, in the case of a
22 hospital provider that did not conduct, operate, or maintain a
23 hospital in 2005, the assessment for that State fiscal year
24 shall be computed on the basis of hypothetical occupied bed
25 days for the full calendar year as determined by the Illinois
26 Department. Notwithstanding any other provision in this

1 Article, for the portion of State fiscal year 2012 beginning
2 June 10, 2012 through June 30, 2012, and for State fiscal years
3 2013 through 2018, in the case of a hospital provider that did
4 not conduct, operate, or maintain a hospital in 2009, the
5 assessment under subsection (b-5) of Section 5A-2 for that
6 State fiscal year shall be computed on the basis of
7 hypothetical gross outpatient revenue for the full calendar
8 year as determined by the Illinois Department.

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

19 (f) Every hospital provider subject to assessment under
20 this Article shall keep sufficient records to permit the
21 determination of adjusted gross hospital revenue for the
22 hospital's fiscal year. All such records shall be kept in the
23 English language and shall, at all times during regular
24 business hours of the day, be subject to inspection by the
25 Illinois Department or its duly authorized agents and
26 employees.

1 (g) The Illinois Department may, by rule, provide a
2 hospital provider a reasonable opportunity to request a
3 clarification or correction of any clerical or computational
4 errors contained in the calculation of its assessment, but such
5 corrections shall not extend to updating the cost report
6 information used to calculate the assessment.

7 (h) (Blank).

8 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;
9 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.
10 7-20-15.)

11 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

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

21 (1) For making payments to hospitals as required under
22 this Code, under the Children's Health Insurance Program
23 Act, under the Covering ALL KIDS Health Insurance Act, and
24 under the Long Term Acute Care Hospital Quality Improvement
25 Transfer Program Act.

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

5 (3) For payment of administrative expenses incurred by
6 the Illinois Department or its agent in performing
7 activities under this Code, under the Children's Health
8 Insurance Program Act, under the Covering ALL KIDS Health
9 Insurance Act, and under the Long Term Acute Care Hospital
10 Quality Improvement Transfer Program Act.

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

14 (5) For making transfers, as those transfers are
15 authorized in the proceedings authorizing debt under the
16 Short Term Borrowing Act, but transfers made under this
17 paragraph (5) shall not exceed the principal amount of debt
18 issued in anticipation of the receipt by the State of
19 moneys to be deposited into the Fund.

20 (6) For making transfers to any other fund in the State
21 treasury, but transfers made under this paragraph (6) shall
22 not exceed the amount transferred previously from that
23 other fund into the Hospital Provider Fund plus any
24 interest that would have been earned by that fund on the
25 monies that had been transferred.

26 (6.5) For making transfers to the Healthcare Provider

1 Relief Fund, except that transfers made under this
2 paragraph (6.5) shall not exceed \$60,000,000 in the
3 aggregate.

4 (7) For making transfers not exceeding the following
5 amounts, related to State fiscal years 2013 through 2018,
6 to the following designated funds:

7	Health and Human Services Medicaid Trust	
8	Fund	\$20,000,000
9	Long-Term Care Provider Fund	\$30,000,000
10	General Revenue Fund	\$80,000,000.

11 Transfers under this paragraph shall be made within 7 days
12 after the payments have been received pursuant to the
13 schedule of payments provided in subsection (a) of Section
14 5A-4.

15 (7.1) (Blank).

16 (7.5) (Blank).

17 (7.8) (Blank).

18 (7.9) (Blank).

19 (7.10) For State fiscal year 2014, for making transfers
20 of the moneys resulting from the assessment under
21 subsection (b-5) of Section 5A-2 and received from hospital
22 providers under Section 5A-4 and transferred into the
23 Hospital Provider Fund under Section 5A-6 to the designated
24 funds not exceeding the following amounts in that State
25 fiscal year:

26	Healthcare Provider Relief Fund	\$100,000,000
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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 The additional amount of transfers in this paragraph
6 (7.10), authorized by Public Act 98-651, shall be made
7 within 10 State business days after June 16, 2014 (the
8 effective date of Public Act 98-651). That authority shall
9 remain in effect even if Public Act 98-651 does not become
10 law until State fiscal year 2015.

11 (7.10a) For State fiscal years 2015 through 2018, for
12 making transfers of the moneys resulting from the
13 assessment under subsection (b-5) of Section 5A-2 and
14 received from hospital providers under Section 5A-4 and
15 transferred into the Hospital Provider Fund under Section
16 5A-6 to the designated funds not exceeding the following
17 amounts related to each State fiscal year:

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

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 (7.11) (Blank).

24 (7.12) For State fiscal year 2013, for increasing by
25 21/365ths the transfer of the moneys resulting from the
26 assessment under subsection (b-5) of Section 5A-2 and

1 received from hospital providers under Section 5A-4 for the
2 portion of State fiscal year 2012 beginning June 10, 2012
3 through June 30, 2012 and transferred into the Hospital
4 Provider Fund under Section 5A-6 to the designated funds
5 not exceeding the following amounts in that State fiscal
6 year:

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

8 Since the federal Centers for Medicare and Medicaid
9 Services approval of the assessment authorized under
10 subsection (b-5) of Section 5A-2, received from hospital
11 providers under Section 5A-4 and the payment methodologies
12 to hospitals required under Section 5A-12.4 was not
13 received by the Department until State fiscal year 2014 and
14 since the Department made retroactive payments during
15 State fiscal year 2014 related to the referenced period of
16 June 2012, the transfer authority granted in this paragraph
17 (7.12) is extended through the date that is 10 State
18 business days after June 16, 2014 (the effective date of
19 Public Act 98-651).

20 (7.13) In addition to any other transfers authorized
21 under this Section, for State fiscal years 2017 and 2018,
22 for making transfers to the Healthcare Provider Relief Fund
23 of moneys collected from the ACA Assessment Adjustment
24 authorized under subsections (a) and (b-5) of Section 5A-2
25 and paid by hospital providers under Section 5A-4 into the
26 Hospital Provider Fund under Section 5A-6 for each State

1 fiscal year. Timing of transfers to the Healthcare Provider
2 Relief Fund under this paragraph shall be at the discretion
3 of the Department, but no less frequently than quarterly.

4 (7.14) For making transfers not exceeding the
5 following amounts, related to State fiscal years 2019
6 through 2024, to the following designated funds:

7	<u>Health and Human Services Medicaid Trust</u>	
8	<u>Fund</u>	<u>\$20,000,000</u>
9	<u>Long-Term Care Provider Fund</u>	<u>\$30,000,000</u>
10	<u>Health Care Provider Relief Fund ..</u>	<u>\$325,000,000.</u>

11 Transfers under this paragraph shall be made within 7
12 days after the payments have been received pursuant to the
13 schedule of payments provided in subsection (a) of Section
14 5A-4.

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

17 (9) For making payment to capitated managed care
18 organizations as described in subsections (s) and (t) of
19 Section 5A-12.2 and subsection (r) of Section 5A-12.6 of
20 this Code.

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

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

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

4 (2) All federal matching funds received by the Illinois
5 Department as a result of expenditures made by the Illinois
6 Department that are attributable to moneys deposited in the
7 Fund.

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

10 (3.5) As applicable, proceeds from surety bond
11 payments payable to the Department as referenced in
12 subsection (s) of Section 5A-12.2 of this Code.

13 (4) Moneys transferred from another fund in the State
14 treasury.

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

17 (d) (Blank).

18 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;
19 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.
20 7-20-15; 99-516, eff. 6-30-16; 99-933, eff. 1-27-17; revised
21 2-15-17.)

22 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)
23 Sec. 5A-10. Applicability.

24 (a) The assessment imposed by subsection (a) of Section
25 5A-2 shall cease to be imposed and the Department's obligation

1 to make payments shall immediately cease, and any moneys
2 remaining in the Fund shall be refunded to hospital providers
3 in proportion to the amounts paid by them, if:

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

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

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

16 (B) any rates for payments made under this Article
17 V-A;

18 (C) any changes proposed in State plan amendment
19 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
20 08-07;

21 (D) in relation to any admissions on or after
22 January 1, 2011, a modification in the methodology for
23 calculating outlier payments to hospitals for
24 exceptionally costly stays, for hospitals reimbursed
25 under the diagnosis-related grouping methodology in
26 effect on July 1, 2011; provided that the Department

1 shall be limited to one such modification during the
2 36-month period after the effective date of this
3 amendatory Act of the 96th General Assembly;

4 (E) any changes affecting hospitals authorized by
5 Public Act 97-689;

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

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

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

21 (c) The assessments imposed by subsection (b-5) of Section
22 5A-2 shall not take effect or shall cease to be imposed, the
23 Department's obligation to make payments shall immediately
24 cease, and any moneys remaining in the Fund shall be refunded
25 to hospital providers in proportion to the amounts paid by
26 them, if the payments to hospitals required under Section

1 5A-12.4 or Section 5A-12.6 are not eligible for federal
2 matching funds under Title XIX of the Social Security Act.

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

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

18 (2) for State fiscal years 2013 through 2018, and as
19 provided in Section 5A-16, the Department reduces any
20 supplemental payments made to hospitals below the amounts
21 paid for services provided in State fiscal year 2011 as
22 implemented by administrative rules adopted and in effect
23 on or prior to June 30, 2011, except for any changes
24 affecting hospitals authorized in Public Act 97-689 and any
25 changes authorized by Section 14-12 of this Code, and
26 except for any changes authorized under Section 5A-15, and

1 except for any changes authorized under Section 5-5b.1; or

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

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

15 (1) the payments to hospitals required under Section
16 5A-12.6 are not eligible for federal matching funds under
17 Title XIX of the Social Security Act; or

18 (2) the Department reduces the overall effective rate
19 of reimbursement to hospitals below the level authorized
20 under Section 14-12 of this Code, as in effect on December
21 31, 2017, except for any changes authorized under Sections
22 14-12 or Section 5A-15 of this Code, and except for any
23 changes authorized under changes to Sections 5A-12.2,
24 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by this
25 amendatory Act of the 100th General Assembly.

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

1 eff. 3-26-15.)

2 (305 ILCS 5/5A-12.5)

3 Sec. 5A-12.5. Affordable Care Act adults; hospital access
4 payments.

5 (a) The Department shall, subject to federal approval,
6 mirror the Medical Assistance hospital reimbursement
7 methodology for Affordable Care Act adults who are enrolled
8 under a fee-for-service or capitated managed care program,
9 including hospital access payments as defined in Section
10 5A-12.2 of this Article and hospital access improvement
11 payments as defined in Section 5A-12.4 of this Article, in
12 compliance with the equivalent rate provisions of the
13 Affordable Care Act.

14 (b) If the fee-for-service payments authorized under this
15 Section are deemed to be increases to payments for a prior
16 period, the Department shall seek federal approval to issue
17 such increases for the payments made through the period ending
18 on June 30, 2018, or as provided in Section 5A-16, even if such
19 increases are paid out during an extended payment period beyond
20 such date. Payment of such increases beyond such date is
21 subject to federal approval. If the Department receives federal
22 approval of such increases, the Department shall pay such
23 increases on the same schedule as it had used for such payments
24 prior to June 30, 2018.

25 (c) As used in this Section, "Affordable Care Act" is the

1 collective term for the Patient Protection and Affordable Care
2 Act (Pub. L. 111-148) and the Health Care and Education
3 Reconciliation Act of 2010 (Pub. L. 111-152).

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

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

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

8 (a) To preserve and improve access to hospital services,
9 for hospital services rendered on or after July 1, 2018 the
10 Department shall, except for hospitals described in subsection
11 (b) of Section 5A-3, make payments to hospitals as set forth in
12 this Section. Payments under this Section are not due and
13 payable, however, until (i) the methodologies described in this
14 Section are approved by the federal government in an
15 appropriate State Plan amendment and (ii) the assessment
16 imposed under this Article is determined to be a permissible
17 tax under Title XIX of the Social Security Act. In determining
18 the hospital access payments authorized under subsections (f)
19 through (n) of this Section, unless otherwise specified, only
20 Illinois hospitals shall be eligible for a payment and total
21 Medicaid utilization statistics shall be used to determine the
22 payment amount. In determining the hospital access payments
23 authorized under subsection (d) and subsections (f) through (l)
24 of this Section, if a hospital ceases to receive payments from
25 the pool, the payments for all hospitals continuing to receive

1 payments from such pool shall be uniformly adjusted to fully
2 expend the aggregate amount of the pool, with such adjustment
3 being effective on the first day of the second month following
4 the date the hospital ceases to receive payments from such
5 pool.

6 (b) Phase in of funds to claims-based payments and updates.
7 To ensure access to hospital services, the Department may only
8 use funds financed by the assessment authorized under Section
9 5A-2 to increase claims-based payment rates, including
10 applicable policy add-on payments or adjusters, in accordance
11 with this subsection. To increase the claims-based payment
12 rates up to the amounts specified in this subsection, the
13 hospital access payments authorized in subsection (d) and
14 subsections (g) through (l) of this Section shall be uniformly
15 reduced.

16 (1) For State fiscal years 2019 and 2020, up to
17 \$635,000,000 of the total spending financed from the
18 assessment authorized under Section 5A-2 that is intended
19 to pay for hospital services and the hospital supplemental
20 access payments authorized under subsections (d) and (f) of
21 Section 14-12 for payment in State fiscal year 2018 may be
22 used to increase claims-based hospital payment rates as
23 specified under Section 14-12.

24 (2) For State fiscal years 2021 and 2022, up to
25 \$1,164,000,000 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 (3) For State fiscal years 2023, up to \$1,397,000,000
7 of the total spending financed from the assessment
8 authorized under Section 5A-2 that is intended to pay for
9 hospital services and the hospital supplemental access
10 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 (4) For State fiscal years 2024, up to \$1,663,000,000
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 (5) Beginning in State fiscal year 2021, and at least
23 every 24 months thereafter, the Department shall, by rule,
24 update the hospital access payments authorized under this
25 Section to take into account the amount of funds being used
26 to increase claims-based hospital payment rates under

1 Section 14-12 and to apply the most recently available data
2 and information, including data from the most recent base
3 year and qualifying criteria which shall correlate to the
4 updated base year data, to determine a hospital's
5 eligibility for each payment and the amount of the payment
6 authorized under this Section. Any updates of the hospital
7 access payment methodologies shall not result in any
8 diminishment of the aggregate amount of hospital access
9 payment expenditures, except for reductions attributable
10 to the use of such funds to increase claims-based hospital
11 payment rates as authorized by this Section. Nothing in
12 this Section shall be construed as precluding variations in
13 the amount of any individual hospital's access payments.
14 The Department shall publish the proposed rules to update
15 the hospital access payments at least 90 days before their
16 proposed effective date. The proposed rules shall not be
17 adopted using emergency rulemaking authority. The
18 Department shall notify each hospital, in writing, of the
19 impact of these updates on the hospital at least 30
20 calendar days prior to their effective date.

21 (c) The hospital access payments authorized under
22 subsections (d) through (n) of this Section shall be paid in 12
23 equal installments on or before the seventh State business day
24 of each month, except that no payment shall be due within 100
25 days after the later of the date of notification of federal
26 approval of the payment methodologies required under this

1 Section or any waiver required under 42 CFR 433.68, at which
2 time the sum of amounts required under this Section prior to
3 the date of notification is due and payable. Payments under
4 this Section are not due and payable, however, until (i) the
5 methodologies described in this Section are approved by the
6 federal government in an appropriate State Plan amendment and
7 (ii) the assessment imposed under this Article is determined to
8 be a permissible tax under Title XIX of the Social Security
9 Act. The Department may, when practicable, accelerate the
10 schedule upon which payments authorized under this Section are
11 made.

12 (d) Rate increase-based adjustment.

13 (1) From the funds financed by the assessment
14 authorized under Section 5A-2, individual funding pools by
15 category of service shall be established, for Inpatient
16 General Acute Care services in the amount of \$268,051,572,
17 Inpatient Rehab Care services in the amount of \$24,500,610,
18 Inpatient Psychiatric Care service in the amount of
19 \$94,617,812, and Outpatient Care Services in the amount of
20 \$328,828,641.

21 (2) Each Illinois hospital and other hospitals
22 authorized under this subsection, except for long-term
23 acute care hospitals and public hospitals, shall be
24 assigned a pool allocation percentage for each category of
25 service that is equal to the ratio of the hospital's
26 estimated FY2019 claims-based payments including all

1 applicable FY2019 policy adjusters, multiplied by the
2 applicable service credit factor for the hospital, divided
3 by the total of the FY2019 claims-based payments including
4 all FY2019 policy adjusters for each category of service
5 adjusted by each hospital's applicable service credit
6 factor for all qualified hospitals. For each category of
7 service, a hospital shall receive a supplemental payment
8 equal to its pool allocation percentage multiplied by the
9 total pool amount.

10 (3) Effective July 1, 2018, for purposes of determining
11 for State fiscal years 2019 and 2020 the hospitals eligible
12 for the payments authorized under this subsection, the
13 Department shall include children's hospitals located in
14 St. Louis that are designated a Level III perinatal center
15 by the Department of Public Health and also designated a
16 Level I pediatric trauma center by the Department of Public
17 Health as of December 1, 2017.

18 (4) As used in this subsection, "service credit factor"
19 is determined based on a hospital's Rate Year 2017 Medicaid
20 inpatient utilization rate ("MIUR") rounded to the nearest
21 whole percentage, as follows:

22 (A) Tier 1: A hospital with a MIUR equal to or
23 greater than 60% shall have a service credit factor of
24 200%.

25 (B) Tier 2: A hospital with a MIUR equal to or
26 greater than 33% but less than 60% shall have a service

1 credit factor of 100%.

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

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

7 (e) Graduate medical education.

8 (1) The calculation of graduate medical education
9 payments shall be based on the hospital's Medicare cost
10 report ending in Calendar Year 2015, as reported in
11 Medicare cost reports released on October 19, 2016 with
12 data through September 30, 2016. An Illinois hospital
13 reporting intern and resident cost on its Medicare cost
14 report shall be eligible for graduate medical education
15 payments.

16 (2) Each hospital's annualized Medicaid Intern
17 Resident Cost is calculated using annualized intern and
18 resident total costs obtained from Worksheet B Part I,
19 Column 21 and 22 the sum of Lines 30-43, 50-76, 90-93,
20 96-98, and 105-112 multiplied by the percentage that the
21 hospital's Medicaid days (Worksheet S3 Part I, Column 7,
22 Lines 14 and 16-18) comprise of the hospital's total days
23 (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).

24 (3) An annualized Medicaid indirect medical education
25 (IME) payment is calculated for each hospital using its IME
26 payments (Worksheet E Part A, Line 29, Col 1) multiplied by

1 the percentage that its Medicaid days (Worksheet S3 Part I,
2 Column 7, Lines 14 and 16-18) comprise of its Medicare days
3 (Worksheet S3 Part I, Column 6, Lines 14 and 16-18).

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

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

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

23 (1) Each safety-net hospital, as defined in Section
24 5-5e.1 of this Code, for Rate Year 2017 that is not
25 publicly owned shall be paid an outpatient high volume
26 access payment equal to \$40,000,000 multiplied by a

1 fraction, the numerator of which is the hospital's Fiscal
2 Year 2015 outpatient services and the denominator of which
3 is the Fiscal Year 2015 outpatient services for all
4 hospitals eligible under this paragraph for this payment.

5 (2) Each critical access hospital that is not publicly
6 owned shall be paid an outpatient high volume access
7 payment equal to \$55,000,000 multiplied by a fraction, the
8 numerator of which is the hospital's Fiscal Year 2015
9 outpatient services and the denominator of which is the
10 Fiscal Year 2015 outpatient services for all hospitals
11 eligible under this paragraph for this payment.

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

1 or greater than the statewide mean plus one standard
2 deviation; or (iii) a non-publicly owned 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.

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

20 (5) Each tier 3 hospital that is not publicly owned
21 shall be paid an outpatient high volume access payment
22 equal to \$58,000,000 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 3

1 outpatient high volume hospital means a non-publicly owned
2 hospital, excluding a safety-net hospital as defined in
3 Section 5-5e.1 of this Code for Rate Year 2017, with total
4 outpatient services equal to or greater than the regional
5 mean plus 2 standard deviations for all hospitals in the
6 region.

7 (h) Medicaid dependent or high volume hospital access
8 payment.

9 (1) To qualify for a Medicaid dependent hospital access
10 payment, a hospital shall meet one of the following
11 criteria:

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

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

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

22 (2) The Medicaid dependent hospital access payment
23 shall be determined as follows:

24 (A) Each tier 1 hospital shall be paid a Medicaid
25 dependent hospital access payment equal to \$23,000,000
26 multiplied by a fraction, the numerator of which is the

1 hospital's Fiscal Year 2015 total days and the
2 denominator of which is the Fiscal Year 2015 total days
3 for all hospitals eligible under this subparagraph for
4 this payment. A tier 1 Medicaid dependent hospital
5 means a qualifying hospital with a Rate Year 2017
6 Medicaid inpatient utilization rate equal to or
7 greater than the statewide mean but less than the
8 statewide mean plus 0.5 standard deviation.

9 (B) Each tier 2 hospital shall be paid a Medicaid
10 dependent hospital access payment equal to \$15,000,000
11 multiplied by a fraction, the numerator of which is the
12 hospital's Fiscal Year 2015 total days and the
13 denominator of which is the Fiscal Year 2015 total days
14 for all hospitals eligible under this subparagraph for
15 this payment. A tier 2 Medicaid dependent hospital
16 means a qualifying hospital with a Rate Year 2017
17 Medicaid inpatient utilization rate equal to or
18 greater than the statewide mean plus 0.5 standard
19 deviations but less than the statewide mean plus one
20 standard deviation.

21 (C) Each tier 3 hospital shall be paid a Medicaid
22 dependent hospital access payment equal to \$15,000,000
23 multiplied by a fraction, the numerator of which is the
24 hospital's Fiscal Year 2015 total days and the
25 denominator of which is the Fiscal Year 2015 total days
26 for all hospitals eligible under this subparagraph for

1 this payment. A tier 3 Medicaid dependent hospital
2 means a qualifying hospital with a Rate Year 2017
3 Medicaid inpatient utilization rate equal to or
4 greater than the statewide mean plus one standard
5 deviation but less than the statewide mean plus 1.5
6 standard deviations.

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

19 (E) Each tier 5 hospital shall be paid a Medicaid
20 dependent hospital access payment equal to \$75,000,000
21 multiplied by a fraction, the numerator of which is the
22 hospital's Fiscal Year 2015 total days and the
23 denominator of which is the Fiscal Year 2015 total days
24 for all hospitals eligible under this subparagraph for
25 this payment. A tier 5 Medicaid dependent hospital
26 means a qualifying hospital with a Rate Year 2017

1 Medicaid inpatient utilization rate equal to or
2 greater than the statewide mean plus 2 standard
3 deviations.

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

20 (i) Perinatal care access payment.

21 (1) Each Illinois non-publicly owned hospital
22 designated a Level II or II+ perinatal center by the
23 Department of Public Health as of December 1, 2017 shall be
24 paid an access payment equal to \$200,000,000 multiplied by
25 a fraction, the numerator of which is the hospital's Fiscal
26 Year 2015 total admissions and the denominator of which is

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

3 (2) Each Illinois non-publicly owned hospital
4 designated a Level III perinatal center by the Department
5 of Public Health as of December 1, 2017 shall be paid an
6 access payment equal to \$100,000,000 multiplied by a
7 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 (j) Trauma care access payment.

12 (1) Each Illinois non-publicly owned hospital
13 designated a Level I trauma center by the Department of
14 Public Health as of December 1, 2017 shall be paid an
15 access payment equal to \$160,000,000 multiplied by a
16 fraction, the numerator of which is the hospital's Fiscal
17 Year 2015 total admissions and the denominator of which is
18 the Fiscal Year 2015 total admissions for all hospitals
19 eligible under this paragraph for this payment.

20 (2) Each Illinois non-publicly owned hospital
21 designated a Level II trauma center by the Department of
22 Public Health as of December 1, 2017 shall be paid an
23 access payment equal to \$200,000,000 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 (k) Perinatal and trauma center access payment.

3 (1) Each Illinois non-publicly owned hospital
4 designated a Level III perinatal center and a Level I or II
5 trauma center by the Department of Public Health as of
6 December 1, 2017, and that has a Rate Year 2017 Medicaid
7 inpatient utilization rate equal to or greater than 20% and
8 a calendar year 2015 occupancy ratio equal to or greater
9 than 50%, shall be paid an access payment equal to
10 \$160,000,000 multiplied by a fraction, the numerator of
11 which is the hospital's Fiscal Year 2015 total admissions
12 and the denominator of which is the Fiscal Year 2015 total
13 admissions for all hospitals eligible under this paragraph
14 for this payment.

15 (2) Each Illinois non-publicly owned hospital
16 designated a Level II or II+ perinatal center and a Level I
17 or II trauma center by the Department of Public Health as
18 of December 1, 2017, and that has a Rate Year 2017 Medicaid
19 inpatient utilization rate equal to or greater than 20% and
20 a calendar year 2015 occupancy ratio equal to or greater
21 than 50%, shall be paid an access payment equal to
22 \$200,000,000 multiplied by a fraction, the numerator of
23 which is the hospital's Fiscal Year 2015 total admissions
24 and the denominator of which is the Fiscal Year 2015 total
25 admissions for all hospitals eligible under this paragraph
26 for this payment.

1 (l) Long-term acute care access payment. Each Illinois
2 non-publicly owned long-term acute care hospital that has a
3 Rate Year 2017 Medicaid inpatient utilization rate equal to or
4 greater than 25% and a calendar year 2015 occupancy ratio equal
5 to or greater than 60% shall be paid an access payment equal to
6 \$19,000,000 multiplied by a fraction, the numerator of which is
7 the hospital's Fiscal Year 2015 general acute care admissions
8 and the denominator of which is the Fiscal Year 2015 general
9 acute care admissions for all hospitals eligible under this
10 subsection for this payment.

11 (m) Small public hospital access payment.

12 (1) As used in this subsection, "small public hospital"
13 means any Illinois publicly owned hospital which is not a
14 "large public hospital" as described in 89 Ill. Adm. Code
15 148.25(a).

16 (2) Each small public hospital shall be paid an
17 inpatient access payment equal to \$2,825,000 multiplied by
18 a fraction, the numerator of which is the hospital's Fiscal
19 Year 2015 total days and the denominator of which is the
20 Fiscal Year 2015 total days for all hospitals under this
21 paragraph for this payment.

22 (3) Each small public hospital shall be paid an
23 outpatient access payment equal to \$24,000,000 multiplied
24 by a fraction, the numerator of which is the hospital's
25 Fiscal Year 2015 outpatient services and the denominator of
26 which is the Fiscal Year 2015 outpatient services for all

1 hospitals eligible under this paragraph for this payment.

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

19 (o) For purposes of this Section, a hospital that is
20 enrolled to provide Medicaid services during State fiscal year
21 2015 shall have its utilization and associated reimbursements
22 annualized prior to the payment calculations being performed
23 under this Section.

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

26 "General acute care admissions" means, for a given

1 hospital, the sum of inpatient hospital admissions provided to
2 recipients of medical assistance under Title XIX of the Social
3 Security Act for general acute care, excluding admissions for
4 individuals eligible for Medicare under Title XVIII of the
5 Social Security Act (Medicaid/Medicare crossover admissions),
6 as tabulated from the Department's paid claims data for general
7 acute care admissions occurring during State fiscal year 2015
8 that was adjudicated by the Department through October 28,
9 2016.

10 "Occupancy ratio" is determined utilizing the IDPH
11 Hospital Profile CY15 - Facility Utilization Data - Source 2015
12 Annual Hospital Questionnaire. Utilizes all beds and days
13 including observation days but excludes Long Term Care and
14 Swing bed and their associated beds and days.

15 "Outpatient services" means, for a given hospital, the sum
16 of the number of outpatient encounters identified as unique
17 services provided to recipients of medical assistance under
18 Title XIX of the Social Security Act for general acute care,
19 psychiatric care, and rehabilitation care, excluding
20 outpatient services for individuals eligible for Medicare
21 under Title XVIII of the Social Security Act (Medicaid/Medicare
22 crossover services), as tabulated from the Department's paid
23 claims data for outpatient services occurring during State
24 fiscal year 2015 that was adjudicated by the Department through
25 October 28, 2016.

26 "Total days" means, for a given hospital, the sum of

1 inpatient hospital days provided to recipients of medical
2 assistance under Title XIX of the Social Security Act for
3 general acute care, psychiatric care, and rehabilitation care,
4 excluding days for individuals eligible for Medicare under
5 Title XVIII of the Social Security Act (Medicaid/Medicare
6 crossover days), as tabulated from the Department's paid claims
7 data for total days occurring during State fiscal year 2015
8 that was adjudicated by the Department through October 28,
9 2016.

10 "Total admissions" means, for a given hospital, the sum of
11 inpatient hospital admissions provided to recipients of
12 medical assistance under Title XIX of the Social Security Act
13 for general acute care, psychiatric care, and rehabilitation
14 care, excluding admissions for individuals eligible for
15 Medicare under Title XVIII of that Act (Medicaid/Medicare
16 crossover admissions), as tabulated from the Department's paid
17 claims data for admissions occurring during State fiscal year
18 2015 that was adjudicated by the Department through October 28,
19 2016.

20 (q) Notwithstanding any of the other provisions of this
21 Section, the Department is authorized to adopt rules that
22 change the hospital access payments specified in this Section,
23 but only to the extent necessary to conform to any federally
24 approved amendment to the Title XIX State Plan. Any such rules
25 shall be adopted by the Department as authorized by Section
26 5-50 of the Illinois Administrative Procedure Act.

1 Notwithstanding any other provision of law, any changes
2 implemented as a result of this subsection (q) shall be given
3 retroactive effect so that they shall be deemed to have taken
4 effect as of the effective date of this amendatory Act of the
5 100th General Assembly.

6 (r) On or after July 1, 2018, and no less than annually
7 thereafter, the Department shall increase capitation payments
8 to capitated managed care organizations (MCOs) to equal the
9 aggregate reduction of payments made in this Section to
10 preserve access to hospital services for recipients under the
11 Medical Assistance Program. The aggregate amount of all
12 increased capitation payments to all MCOs for a fiscal year
13 shall at least be the amount needed to avoid reduction in
14 payments authorized under Section 5A-15. Payments to MCOs under
15 this Section shall be consistent with actuarial certification
16 and shall be published by the Department each year. Managed
17 care organizations and hospitals (including through their
18 representative organizations), shall develop and implement
19 methodologies and rates for payments that will preserve and
20 improve access to hospital services for recipients in
21 furtherance of the State's public policy to ensure equal access
22 to covered services to recipients under the Medical Assistance
23 Program. The Department shall make available, on a monthly
24 basis, a report of the capitation payments that are made to
25 each MCO, including the number of enrollees for which such
26 payment is made, the per enrollee amount of the payment, and

1 any adjustments that have been made. Payments to MCOs that
2 would be paid consistent with actuarial certification and
3 enrollment in the absence of the increased capitation payments
4 under this Section shall not be reduced as a consequence of
5 payments made under this subsection.

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

9 (305 ILCS 5/5A-13)

10 Sec. 5A-13. Emergency rulemaking.

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

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

1 Act of the 97th General Assembly is deemed an emergency and
2 necessary for the public interest, safety, and welfare.

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

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

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

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

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

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

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

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

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

9 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;
10 98-651, eff. 6-16-14.)

11 (305 ILCS 5/5A-15)

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

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

16 (1) (i) if such finding is made before payments have
17 been issued, the payments under this Article and the
18 increases in claims-based hospital payment rates specified
19 under Section 14-12 of this Code, as authorized under this
20 amendatory Act of the 100th General Assembly, that exceed
21 the applicable federal upper payment limit shall be reduced
22 uniformly to the extent necessary to comply with the
23 applicable federal upper payment limit; or (ii) if such
24 finding is made after payments have been issued, the
25 payments under this Article that exceed the applicable

1 federal upper payment limit shall be reduced uniformly to
2 the extent necessary to comply with the applicable federal
3 upper payment limit; and

4 (2) any assessment rate imposed under this Article
5 shall be reduced such that the aggregate assessment is
6 reduced by the same percentage reduction applied in
7 paragraph (1); and

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

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

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

15 (305 ILCS 5/5A-16 new)

16 Sec. 5A-16. State fiscal year 2019 implementation
17 protection. To preserve access to hospital services, it is the
18 intent of the General Assembly that there not be a gap in
19 payments to hospitals while the changes authorized under this
20 amendatory Act of the 100th General Assembly are being reviewed
21 by the federal Centers for Medicare and Medicaid Services and
22 implemented by the Department. Therefore, pending the review
23 and approval of the changes to the assessment and hospital
24 reimbursement methodologies authorized under this amendatory
25 Act of the 100th General Assembly by the federal Centers for

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

17 Notwithstanding any other provision of this Code, if the
18 federal Centers for Medicare and Medicaid Services should
19 approve the continuation of the reimbursement methodologies
20 and payments to hospitals under Sections 5A-12.2, 5A-12.4,
21 5A-12.5, and Section 14-12, as they are in effect on June 30,
22 2018, until the new and revised methodologies and payments
23 authorized under Sections 5A-12.6 and Section 14-12 of this
24 amendatory Act of the 100th General Assembly are federally
25 approved, then the reimbursement methodologies and payments to
26 hospitals under Sections 5A-12.2, 5A-12.4, 5A-12.5, and 14-12,

1 and the assessments imposed under Section 5A-2, as they are in
2 effect on June 30, 2018, shall continue until the effective
3 date of the new and revised methodologies and payments, which
4 shall be the first day of the second month following the date
5 of approval by the federal Centers for Medicare and Medicaid
6 Services.

7 (305 ILCS 5/12-4.105)

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

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

20 (305 ILCS 5/14-12)

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

24 (a) Inpatient hospital services. Effective for discharges

1 on and after July 1, 2014, reimbursement for inpatient general
2 acute care services shall utilize the All Patient Refined
3 Diagnosis Related Grouping (APR-DRG) software, version 30,
4 distributed by 3MTM Health Information System.

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

11 (2) The Department shall establish a
12 statewide-standardized amount to be used in the inpatient
13 reimbursement system. The Department shall publish these
14 amounts on its website no later than 10 calendar days prior
15 to their effective date.

16 (3) In addition to the statewide-standardized amount,
17 the Department shall develop adjusters to adjust the rate
18 of reimbursement for critical Medicaid providers or
19 services for trauma, transplantation services, perinatal
20 care, and Graduate Medical Education (GME).

21 (4) The Department shall develop add-on payments to
22 account for exceptionally costly inpatient stays,
23 consistent with Medicare outlier principles. Outlier fixed
24 loss thresholds may be updated to control for excessive
25 growth in outlier payments no more frequently than on an
26 annual basis, but at least triennially. Upon updating the

1 fixed loss thresholds, the Department shall be required to
2 update base rates within 12 months.

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

9 (6) Beginning July 1, 2014 and ending on June 30, 2024
10 ~~2018~~, in addition to the statewide-standardized amount,
11 the Department shall develop an adjustor to adjust the rate
12 of reimbursement for safety-net hospitals defined in
13 Section 5-5e.1 of this Code excluding pediatric hospitals.

14 (7) Beginning July 1, 2014 and ending on June 30, 2020,
15 or upon implementation of inpatient psychiatric rate
16 increases as described in subsection (n) of Section 5A-12.6
17 ~~2018~~, in addition to the statewide-standardized amount,
18 the Department shall develop an adjustor to adjust the rate
19 of reimbursement for Illinois freestanding inpatient
20 psychiatric hospitals that are not designated as
21 children's hospitals by the Department but are primarily
22 treating patients under the age of 21.

23 (7.5) Beginning July 1, 2020, the reimbursement for
24 inpatient psychiatric services shall be so that base claims
25 projected reimbursement is increased by an amount equal to
26 the funds allocated in paragraph (2) of subsection (b) of

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

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

25 (9) Beginning July 1, 2018, in addition to the
26 statewide-standardized amount, the Department shall apply

1 the same adjustor that is applied to trauma cases as of
2 December 31, 2017 to inpatient claims to treat patients
3 with burns, including, but not limited to, APR-DRGs 841,
4 842, 843, and 844.

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

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

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

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

21 Beginning July 1, 2022, the reimbursement for
22 inpatient rehabilitation services shall be uniformly
23 increased so that the \$96 per day add-on as adjusted by the
24 July 1, 2020 increase, is increased by an amount equal to
25 the funds allocated in paragraph (3) of subsection (b) of
26 Section 5A-12.6, less the amount allocated under

1 paragraphs (8) and (9) of this subsection and paragraphs
2 (3) and (4) of subsection (b) multiplied by 0.9%.

3 Beginning July 1, 2023, 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, 2022 increase, is increased by an amount equal to
7 the funds allocated in paragraph (4) 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 (b) Outpatient hospital services. Effective for dates of
12 service on and after July 1, 2014, reimbursement for outpatient
13 services shall utilize the Enhanced Ambulatory Procedure
14 Grouping (E-APG) software, version 3.7 distributed by 3M™
15 Health Information System.

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

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

24 (A) The initial statewide standardized amounts,
25 with the labor portion adjusted by the Calendar Year
26 2013 Medicare Outpatient Prospective Payment System

1 wage index with reclassifications, shall be published
2 by the Department on its website no later than 10
3 calendar days prior to their effective date.

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

15 (3) In addition to the statewide-standardized amounts,
16 the Department shall develop adjusters to adjust the rate
17 of reimbursement for critical Medicaid hospital outpatient
18 providers or services, including outpatient high volume or
19 safety-net hospitals. Beginning July 1, 2018, the
20 outpatient high volume adjustor shall be increased to
21 increase annual expenditures associated with this adjustor
22 by \$79,200,000, based on the State Fiscal Year 2015 base
23 year data and this adjustor shall apply to public
24 hospitals, except for large public hospitals, as defined
25 under 89 Ill. Adm. Code 148.25(a).

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

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

13 (5) Beginning July 1, 2018, the statewide-standardized
14 amounts for outpatient services shall be increased so that
15 base claims projected reimbursement is increased by an
16 amount equal to the funds allocated in paragraph (1) of
17 subsection (b) of Section 5A-12.6, less the amount
18 allocated under paragraphs (8) and (9) of subsection (a)
19 and paragraphs (3) and (4) of this subsection multiplied by
20 46%. Beginning July 1, 2020, the statewide-standardized
21 amounts for outpatient services shall be increased so that
22 base claims projected reimbursement is increased by an
23 amount equal to the funds allocated in paragraph (2) of
24 subsection (b) of Section 5A-12.6, less the amount
25 allocated under paragraphs (8) and (9) of subsection (a)
26 and paragraphs (3) and (4) of this subsection multiplied by

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

16 (c) In consultation with the hospital community, the
17 Department is authorized to replace 89 Ill. Admin. Code 152.150
18 as published in 38 Ill. Reg. 4980 through 4986 within 12 months
19 of the effective date of this amendatory Act of the 98th
20 General Assembly. If the Department does not replace these
21 rules within 12 months of the effective date of this amendatory
22 Act of the 98th General Assembly, the rules in effect for
23 152.150 as published in 38 Ill. Reg. 4980 through 4986 shall
24 remain in effect until modified by rule by the Department.
25 Nothing in this subsection shall be construed to mandate that
26 the Department file a replacement rule.

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

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

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

25 (d-5) Hospital transformation program. The Department, in
26 conjunction with the Hospital Transformation Review Committee

1 created under subsection (d-5), shall develop a hospital
2 transformation program to provide financial assistance to
3 hospitals in transforming their services and care models to
4 better align with the needs of the communities they serve. The
5 payments authorized in this Section shall be subject to
6 approval by the federal government.

7 (1) Phase 1. In State fiscal years 2019 through 2020,
8 the Department shall allocate funds from the transitional
9 access hospital pool to create a hospital transformation
10 pool of at least \$262,906,870 annually and make hospital
11 transformation payments to hospitals. Subject to Section
12 5A-16, in State fiscal years 2019 and 2020, an Illinois
13 hospital that received either a transitional hospital
14 access payment under subsection (d) or a supplemental
15 payment under subsection (f) of this Section in State
16 fiscal year 2018, shall receive a hospital transformation
17 payment as follows:

18 (A) If the hospital's Rate Year 2017 Medicaid
19 inpatient utilization rate is equal to or greater than
20 45%, the hospital transformation payment shall be
21 equal to 100% of the sum of its transitional hospital
22 access payment authorized under subsection (d) and any
23 supplemental payment authorized under subsection (f).

24 (B) If the hospital's Rate Year 2017 Medicaid
25 inpatient utilization rate is equal to or greater than
26 25% but less than 45%, the hospital transformation

1 payment shall be equal to 75% of the sum of its
2 transitional hospital access payment authorized under
3 subsection (d) and any supplemental payment authorized
4 under subsection (f).

5 (C) If the hospital's Rate Year 2017 Medicaid
6 inpatient utilization rate is less than 25%, the
7 hospital transformation payment shall be equal to 50%
8 of the sum of its transitional hospital access payment
9 authorized under subsection (d) and any supplemental
10 payment authorized under subsection (f).

11 (2) Phase 2. During State fiscal years 2021 and 2022,
12 the Department shall allocate funds from the transitional
13 access hospital pool to create a hospital transformation
14 pool annually and make hospital transformation payments to
15 hospitals participating in the transformation program. Any
16 hospital may seek transformation funding in Phase 2. Any
17 hospital that seeks transformation funding in Phase 2 to
18 update or repurpose the hospital's physical structure to
19 transition to a new delivery model, must submit to the
20 Department in writing a transformation plan, based on the
21 Department's guidelines, that describes the desired
22 delivery model with projections of patient volumes by
23 service lines and projected revenues, expenses, and net
24 income that correspond to the new delivery model. In Phase
25 2, subject to the approval of rules, the Department may use
26 the hospital transformation pool to increase base rates,

1 develop new adjustors, adjust current adjustors, or
2 develop new access payments in order to support and
3 incentivize hospitals to pursue such transformation. In
4 developing such methodologies, the Department shall ensure
5 that the entire hospital transformation pool continues to
6 be expended to ensure access to hospital services or to
7 support organizations that had received hospital
8 transformation payments under this Section.

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

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

26 (C) As provided in subsection (a-20) of Section

1 32.5 of the Emergency Medical Services (EMS) Systems
2 Act, a hospital that received hospital transformation
3 payments under this Section may convert to a
4 freestanding emergency center. To be eligible for such
5 a conversion, the hospital must submit to the
6 Department of Public Health certification from the
7 Department, approved by the Hospital Transformation
8 Review Committee, that the project is a part of the
9 hospital's transformation.

10 (3) Within 6 months after the effective date of this
11 amendatory Act of the 100th General Assembly, the
12 Department, in conjunction with the Hospital
13 Transformation Review Committee, shall develop and adopt,
14 by rule, the goals, objectives, policies, standards,
15 payment models, or criteria to be applied in Phase 2 of the
16 program to allocate the hospital transformation funds. The
17 goals, objectives, and policies to be considered may
18 include, but are not limited to, achieving unmet needs of a
19 community that a hospital serves such as behavioral health
20 services, outpatient services, or drug rehabilitation
21 services; attaining certain quality or patient safety
22 benchmarks for health care services; or improving the
23 coordination, effectiveness, and efficiency of care
24 delivery. Notwithstanding any other provision of law, any
25 rule adopted in accordance with this subsection (d-5) may
26 be submitted to the Joint Committee on Administrative Rules

1 for approval only if the rule has first been approved by 9
2 of the 14 members of the Hospital Transformation Review
3 Committee.

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

1 perform the functions described in this Section and advise
2 and consult with the Director in the administration of this
3 Section. In addition to reviewing and approving the
4 policies, procedures, and rules for the hospital
5 transformation program, the Committee shall consider and
6 make recommendations related to qualifying criteria and
7 payment methodologies related to safety-net hospitals and
8 children's hospitals. Members of the Committee appointed
9 by the legislative leaders shall be subject to the
10 jurisdiction of the Legislative Ethics Commission, not the
11 Executive Ethics Commission, and all requests under the
12 Freedom of Information Act shall be directed to the
13 applicable Freedom of Information officer for the General
14 Assembly. The Department shall provide operational support
15 to the Committee as necessary.

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

23 (f) Continuation of supplemental payments. Any
24 supplemental payments authorized under Illinois Administrative
25 Code 148 effective January 1, 2014 and that continue during the
26 period of July 1, 2014 through December 31, 2014 shall remain

1 in effect as long as the assessment imposed by Section 5A-2
2 that is in effect on December 31, 2017 remains ~~is~~ in effect.

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

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

23 (i) Except for subsections (g) and (h) of this Section, the
24 Department shall, pursuant to subsection (c) of Section 5-40 of
25 the Illinois Administrative Procedure Act, provide for
26 presentation at the June 2014 hearing of the Joint Committee on

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

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

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

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

24 Section 95. No acceleration or delay. Where this Act makes
25 changes in a statute that is represented in this Act by text

1 that is not yet or no longer in effect (for example, a Section
2 represented by multiple versions), the use of that text does
3 not accelerate or delay the taking effect of (i) the changes
4 made by this Act or (ii) provisions derived from any other
5 Public Act.

6 Section 99. Effective date. This Act takes effect upon
7 becoming law, but this Act does not take effect at all unless
8 Senate Bill 1573 of the 100th General Assembly, as amended,
9 becomes law.