Rep. Gregory Harris

Filed: 2/6/2018

AMENDMENT TO SENATE BILL 1773

AMENDMENT NO. _____. Amend Senate Bill 1773, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. The Illinois Administrative Procedure Act is amended by changing Section 5-45 and by adding Section 5-46.3 as follows:

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

Sec. 5-45. Emergency rulemaking.

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

(b) If any agency finds that an emergency exists that requires adoption of a rule upon fewer days than is required by Section 5-40 and states in writing its reasons for that finding, the agency may adopt an emergency rule without prior

notice or hearing upon filing a notice of emergency rulemaking with the Secretary of State under Section 5-70. The notice shall include the text of the emergency rule and shall be published in the Illinois Register. Consent orders or other court orders adopting settlements negotiated by an agency may be adopted under this Section. Subject to applicable constitutional or statutory provisions, an emergency rule becomes effective immediately upon filing under Section 5-65 or at a stated date less than 10 days thereafter. The agency's finding and a statement of the specific reasons for the finding shall be filed with the rule. The agency shall take reasonable and appropriate measures to make emergency rules known to the persons who may be affected by them.

(c) An emergency rule may be effective for a period of not longer than 150 days, but the agency's authority to adopt an identical rule under Section 5-40 is not precluded. No emergency rule may be adopted more than once in any 24-month period, except that this limitation on the number of emergency rules that may be adopted in a 24-month period does not apply to (i) emergency rules that make additions to and deletions from the Drug Manual under Section 5-5.16 of the Illinois Public Aid Code or the generic drug formulary under Section 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act, (iii) emergency rules adopted by the Illinois

Department of Public Health under subsections (a) through (i) of Section 2 of the Department of Public Health Act when necessary to protect the public's health, (iv) emergency rules adopted pursuant to subsection (n) of this Section, (v) emergency rules adopted pursuant to subsection (o) of this Section, or (vi) emergency rules adopted pursuant to subsection (c-5) of this Section. Two or more emergency rules having substantially the same purpose and effect shall be deemed to be a single rule for purposes of this Section.

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

(d) In order to provide for the expeditious and timely implementation of the State's fiscal year 1999 budget, emergency rules to implement any provision of Public Act 90-587 or 90-588 or any other budget initiative for fiscal year 1999 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125

do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

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

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

deemed to be necessary for the public interest, safety, and welfare.

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

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

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

(j) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2005 budget as provided under the Fiscal Year 2005 Budget Implementation (Human Services) Act, emergency rules to implement any provision of the Fiscal Year 2005 Budget Implementation (Human Services) Act may be adopted in accordance with this Section by the agency charged with administering that provision, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (j). The Department of Public Aid may also adopt rules under this subsection (j) necessary to administer the Illinois Public Aid Code and the Children's Health Insurance Program Act. The adoption of emergency rules

authorized by this subsection (j) shall be deemed to be necessary for the public interest, safety, and welfare.

(k) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2006 budget, emergency rules to implement any provision of Public Act 94-48 or any other budget initiative for fiscal year 2006 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (k). The Department of Healthcare and Family Services may also adopt rules under this subsection (k) necessary to administer the Illinois Public Aid Code, the Senior Citizens and Persons with Disabilities Property Tax Relief Act, the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act (now the Illinois Prescription Drug Discount Program Act), and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (k) shall be deemed to be necessary for the public interest, safety, and welfare.

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2007 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2007, including rules effective July 1, 2007, in accordance with this

subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (l) shall be deemed to be necessary for the public interest, safety, and welfare.

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

(n) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2010 budget, emergency rules to implement any provision of Public Act 96-45 or any other budget initiative authorized by the 96th General Assembly for fiscal year 2010 may be adopted

in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (n) shall be deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (n) shall apply only to rules promulgated during Fiscal Year 2010.

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

(p) In order to provide for the expeditious and timely implementation of the provisions of Public Act 97-689, emergency rules to implement any provision of Public Act 97-689 may be adopted in accordance with this subsection (p) by the agency charged with administering that provision or initiative. The 150-day limitation of the effective period of emergency rules does not apply to rules adopted under this

subsection (p), and the effective period may continue through June 30, 2013. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (p). The adoption of emergency rules authorized by this subsection (p) is deemed to be necessary for the public interest, safety, and welfare.

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

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

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

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

(u) In order to provide for the expeditious and timely

implementation of the provisions of the Burn Victims Relief Act, emergency rules to implement any provision of the Act may be adopted in accordance with this subsection (u) by the Department of Insurance. The rulemaking authority granted in this subsection (u) shall apply only to those rules adopted prior to December 31, 2015. The adoption of emergency rules authorized by this subsection (u) is deemed to be necessary for the public interest, safety, and welfare.

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

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

(x) In order to provide for the expeditious and timely implementation of the provisions of Public Act 99-906,

emergency rules to implement subsection (i) of Section 16-115D, subsection (g) of Section 16-128A, and subsection (a) of Section 16-128B of the Public Utilities Act may be adopted in accordance with this subsection (x) by the Illinois Commerce Commission. The rulemaking authority granted in this subsection (x) shall apply only to those rules adopted within 180 days after June 1, 2017 (the effective date of Public Act 99-906). The adoption of emergency rules authorized by this subsection (x) is deemed to be necessary for the public interest, safety, and welfare.

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

(z) In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 100th General Assembly, emergency rules to implement the

changes made by this amendatory Act of the 100th General Assembly to Section 4.7 of the Lobbyist Registration Act may be adopted in accordance with this subsection (z) by the Secretary of State. The adoption of emergency rules authorized by this subsection (z) is deemed to be necessary for the public interest, safety, and welfare.

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

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

(5 ILCS 100/5-46.3 new)

Sec. 5-46.3. Approval of rules to implement the hospital transformation program. Notwithstanding any other provision of

this Act, the Department of Healthcare and Family Services may not file, the Secretary of State may not accept, and the Joint Committee on Administrative Rules may not consider any rules adopted in accordance to subsection (d-5) of Section 14-12 of the Illinois Public Aid Code unless the rules have been approved by 7 of the 10 members of the Hospital Transformation Review Committee created under subsection (d-5) of Section 14-12 of the Illinois Public Aid Code. Approval of the rules shall be demonstrated by submission of a written document signed by each of the 7 approving members. The Department of Healthcare and Family Services shall submit the written document with signatures, along with a certified copy of each rule, to the Secretary of State.

Section 2. The Illinois Health Facilities Planning Act is amended by changing Section 3 as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) Any project the Department of Healthcare and Family Service certifies was approved by the Hospital Transformation Review Committee as a project subject to the hospital's transformation under subsection (d-5) of Section 14-12 of the Illinois Public Aid Code, provided the hospital shall submit the certification to the Board.

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

(1) Federally-owned facilities.

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

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

facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to review.

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

"Non-clinical service area" means an area (i) for the benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the

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

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

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

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

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

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

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

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

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

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

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

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

"Charity care" means care provided by a health care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) Any project the Department of Healthcare and Family Service certifies was approved by the Hospital Transformation Review Committee as a project subject to the hospital's transformation under subsection (d-5) of Section 14-12 of the Illinois Public Aid Code, provided the hospital shall submit the certification to the Board.

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

(1) Federally-owned facilities.

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

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

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

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

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

(7) The closure of an entity or a portion of an entity licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act, with the exception of

facilities operated by a county or Illinois Veterans Homes, that elect to convert, in whole or in part, to an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act and with the exception of a facility licensed under the Specialized Mental Health Rehabilitation Act of 2013 in connection with a proposal to close a facility and re-establish the facility in another location.

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

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's

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

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

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

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

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

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

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is

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

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

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Unless otherwise interdependent, or submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a

single debt instrument shall not be grouped together as one project. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

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

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

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

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

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

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

"Physician" means a person licensed to practice in

accordance with the Medical Practice Act of 1987, as amended.

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

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

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

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

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

Ambulatory Surgical Treatment Center Act.

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

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

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

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

"Category of service" means a grouping by generic class of various types or levels of support functions, equipment, care, or treatment provided to patients or residents, including, but not limited to, classes such as medical-surgical, pediatrics, or cardiac catheterization. A category of service may include subcategories or levels of care that identify a particular degree or type of care within the category of service. Nothing in this definition shall be construed to include the practice

of a physician or other licensed health care professional while functioning in an office providing for the care, diagnosis, or treatment of patients. A category of service that is subject to the Board's jurisdiction must be designated in rules adopted by the Board.

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

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

Section 5. The Illinois Procurement Code is amended by changing Section 1-10 as follows:

(30 ILCS 500/1-10)

Sec. 1-10. Application.

(a) This Code applies only to procurements for which bidders, offerors, potential contractors, or contractors were first solicited on or after July 1, 1998. This Code shall not be construed to affect or impair any contract, or any provision of a contract, entered into based on a solicitation prior to the implementation date of this Code as described in Article 99, including but not limited to any covenant entered into with respect to any revenue bonds or similar instruments. All procurements for which contracts are solicited between the

effective date of Articles 50 and 99 and July 1, 1998 shall be substantially in accordance with this Code and its intent.

(b) This Code shall apply regardless of the source of the funds with which the contracts are paid, including federal assistance moneys. This ~~Except as specifically provided in this Code, this~~ Code shall not apply to:

(1) Contracts between the State and its political subdivisions or other governments, or between State governmental bodies, except as specifically provided in this Code.

(2) Grants, except for the filing requirements of Section 20-80.

(3) Purchase of care, except as provided in Section 5-30.6 of the Illinois Public Aid Code and this Section.

(4) Hiring of an individual as employee and not as an independent contractor, whether pursuant to an employment code or policy or by contract directly with that individual.

(5) Collective bargaining contracts.

(6) Purchase of real estate, except that notice of this type of contract with a value of more than $25,000 must be published in the Procurement Bulletin within 10 calendar days after the deed is recorded in the county of jurisdiction. The notice shall identify the real estate purchased, the names of all parties to the contract, the value of the contract, and the effective date of the

contract.

(7) Contracts necessary to prepare for anticipated litigation, enforcement actions, or investigations, provided that the chief legal counsel to the Governor shall give his or her prior approval when the procuring agency is one subject to the jurisdiction of the Governor, and provided that the chief legal counsel of any other procuring entity subject to this Code shall give his or her prior approval when the procuring entity is not one subject to the jurisdiction of the Governor.

(8) (Blank).

(9) Procurement expenditures by the Illinois Conservation Foundation when only private funds are used.

(10) (Blank).

(11) Public-private agreements entered into according to the procurement requirements of Section 20 of the Public-Private Partnerships for Transportation Act and design-build agreements entered into according to the procurement requirements of Section 25 of the Public-Private Partnerships for Transportation Act.

(12) Contracts for legal, financial, and other professional and artistic services entered into on or before December 31, 2018 by the Illinois Finance Authority in which the State of Illinois is not obligated. Such contracts shall be awarded through a competitive process authorized by the Board of the Illinois Finance Authority

and are subject to Sections 5-30, 20-160, 50-13, 50-20, 50-35, and 50-37 of this Code, as well as the final approval by the Board of the Illinois Finance Authority of the terms of the contract.

(13) Contracts for services, commodities, and equipment to support the delivery of timely forensic science services in consultation with and subject to the approval of the Chief Procurement Officer as provided in subsection (d) of Section 5-4-3a of the Unified Code of Corrections, except for the requirements of Sections 20-60, 20-65, 20-70, and 20-160 and Article 50 of this Code; however, the Chief Procurement Officer may, in writing with justification, waive any certification required under Article 50 of this Code. For any contracts for services which are currently provided by members of a collective bargaining agreement, the applicable terms of the collective bargaining agreement concerning subcontracting shall be followed.

On and after January 1, 2019, this paragraph (13), except for this sentence, is inoperative.

(14) Contracts for participation expenditures required by a domestic or international trade show or exhibition of an exhibitor, member, or sponsor.

(15) Contracts with a railroad or utility that requires the State to reimburse the railroad or utilities for the relocation of utilities for construction or other public

purpose. Contracts included within this paragraph (15) shall include, but not be limited to, those associated with: relocations, crossings, installations, and maintenance. For the purposes of this paragraph (15), "railroad" means any form of non-highway ground transportation that runs on rails or electromagnetic guideways and "utility" means: (1) public utilities as defined in Section 3-105 of the Public Utilities Act, (2) telecommunications carriers as defined in Section 13-202 of the Public Utilities Act, (3) electric cooperatives as defined in Section 3.4 of the Electric Supplier Act, (4) telephone or telecommunications cooperatives as defined in Section 13-212 of the Public Utilities Act, (5) rural water or waste water systems with 10,000 connections or less, (6) a holder as defined in Section 21-201 of the Public Utilities Act, and (7) municipalities owning or operating utility systems consisting of public utilities as that term is defined in Section 11-117-2 of the Illinois Municipal Code.

Notwithstanding any other provision of law, for contracts entered into on or after October 1, 2017 under an exemption provided in any paragraph of this subsection (b), except paragraph (1), (2), or (5), each State agency shall post to the appropriate procurement bulletin the name of the contractor, a description of the supply or service provided, the total amount of the contract, the term of the contract, and the exception to

the Code utilized. The chief procurement officer shall submit a report to the Governor and General Assembly no later than November 1 of each year that shall include, at a minimum, an annual summary of the monthly information reported to the chief procurement officer.

(c) This Code does not apply to the electric power procurement process provided for under Section 1-75 of the Illinois Power Agency Act and Section 16-111.5 of the Public Utilities Act.

(d) Except for Section 20-160 and Article 50 of this Code, and as expressly required by Section 9.1 of the Illinois Lottery Law, the provisions of this Code do not apply to the procurement process provided for under Section 9.1 of the Illinois Lottery Law.

(e) This Code does not apply to the process used by the Capital Development Board to retain a person or entity to assist the Capital Development Board with its duties related to the determination of costs of a clean coal SNG brownfield facility, as defined by Section 1-10 of the Illinois Power Agency Act, as required in subsection (h-3) of Section 9-220 of the Public Utilities Act, including calculating the range of capital costs, the range of operating and maintenance costs, or the sequestration costs or monitoring the construction of clean coal SNG brownfield facility for the full duration of construction.

(f) (Blank).

(g) (Blank).

(h) This Code does not apply to the process to procure or contracts entered into in accordance with Sections 11-5.2 and 11-5.3 of the Illinois Public Aid Code.

(i) Each chief procurement officer may access records necessary to review whether a contract, purchase, or other expenditure is or is not subject to the provisions of this Code, unless such records would be subject to attorney-client privilege.

(j) This Code does not apply to the process used by the Capital Development Board to retain an artist or work or works of art as required in Section 14 of the Capital Development Board Act.

(k) This Code does not apply to the process to procure contracts, or contracts entered into, by the State Board of Elections or the State Electoral Board for hearing officers appointed pursuant to the Election Code.

(l) This Code does not apply to the processes used by the Illinois Student Assistance Commission to procure supplies and services paid for from the private funds of the Illinois Prepaid Tuition Fund. As used in this subsection (l), "private funds" means funds derived from deposits paid into the Illinois Prepaid Tuition Trust Fund and the earnings thereon.

(Source: P.A. 99-801, eff. 1-1-17; 100-43, eff. 8-9-17.)

Section 10. The Emergency Medical Services (EMS) Systems

Act is amended by changing Section 32.5 as follows:

(210 ILCS 50/32.5)

Sec. 32.5. Freestanding Emergency Center.

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

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

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

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

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

(B) equipment standards; and

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

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

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

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

(7) (blank);

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

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

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

(11) submits to the Department, on a quarterly basis,

the FEC's morbidity and mortality rates for patients treated at the FEC and other data determined to be relevant by the Department;

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

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

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

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

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

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

(a-5) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility that is located in a county that does not have a licensed general acute care hospital if the facility's application for a permit from the Illinois Health Facilities Planning Board has

been deemed complete by the Department of Public Health by January 1, 2014 and if the facility complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

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

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

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

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

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

(3) the facility complies with the requirements set forth in paragraphs (1) through (17), provided however that the FEC may be located in a municipality with a population greater than 50,000 inhabitants and shall be exempt from the requirements of the Health Facilities Planning Act if the Department of Healthcare and Family Service has certified the conversion to an FEC was approved by the Hospital Transformation Review Committee as a project subject to the hospital's transformation under subsection (d-5) of Section 14-12 of the Illinois Public Aid Code; and

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

(b) The Department shall:

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

(2) suspend, revoke, refuse to issue, or refuse to renew the license of any FEC, after notice and an opportunity for a hearing, when the Department finds that the FEC has failed to comply with the standards and

requirements of the Act or rules adopted by the Department under the Act;

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

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

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

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-5.02, 5-5e.1, 5-30.1, 5A-2, 5A-4, 5A-5, 5A-8, 5A-10, 5A-12.5, 5A-13, 5A-14, 5A-15, 12-4.105, and 14-12, and by adding Sections 5-30.6, 5-30.7, 5A-12.6, and 5A-16 as follows:

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

Sec. 5-5.02. Hospital reimbursements.

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

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

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

(3) For the purpose of calculating the inpatient

payment rate for each hospital eligible to receive quarterly adjustment payments for uncompensated care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care adjustment payments calculated for each eligible hospital for the uncompensated care rate year, as defined by the Illinois Department, ending on July 31, 1992. The Illinois Department shall determine by rule the adjustment payments for uncompensated care beginning October 1, 1992.

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

(1) Hospitals that are described in Section 1923 of the federal Social Security Act, as now or hereafter amended, except that for rate year 2015 and after a hospital described in Section 1923(b)(1)(B) of the federal Social

Security Act and qualified for the payments described in subsection (c) of this Section for rate year 2014 provided the hospital continues to meet the description in Section 1923(b)(1)(B) in the current determination year; or

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

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

(4) Illinois hospitals that:

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

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard

deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services; or

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

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

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

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid

inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

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

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

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (5) of paragraph (b), excluding

county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) An amendment to the Illinois Title XIX State Plan defining GME shall maximize reimbursement, shall not be

limited to the education programs or special patient care payments allowed under Medicare, and shall include:

(A) inpatient days;

(B) outpatient days;

(C) direct costs;

(D) indirect costs;

(E) managed care days;

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

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

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

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

(5) As used in this subsection, "managed care days" means costs associated with services rendered to enrollees of Medicaid managed care entities. "Medicaid managed care

entities" means any entity which contracts with the Department to provide services paid for on a capitated basis. "Medicaid managed care entities" includes a managed care organization and a managed care community network.

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

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

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

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

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

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

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

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

(3) meets one of the following:

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

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

(b) Definitions. As used in this Section:

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

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

(3) "OBRA form" means form HFS-3834, OBRA '93 data

collection form, for the rate year.

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

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

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

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

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

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

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(3) post-stabilization medical services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act; and

(4) emergency medical conditions, as defined by Section 10 of the Managed Care Reform and Patient Rights Act.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

(d) An MCO shall pay for all post-stabilization services as

a covered service in any of the following situations:

(1) the MCO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further post-stabilization services;

(3) the MCO did not respond to a request to authorize such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

(6) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place; and

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3.

(2) Each MCO shall confirm its receipt of information submitted specific to physician additions or physician deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians, and electronic physician directories must be

updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal to the penalty imposed under the Illinois Insurance Code for any claims not timely paid.

(4) The Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate; and

(2) the Department shall, by December 31, 2016, adopt

rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

(3) The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service

rate, plus all applicable add-ons, when the resulting service relationship is out of network.

(4) The rules shall be applicable for both MCO coverage and fee-for-service coverage.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the

Department.

(g-7) MCO claims processing performance analysis.

(1) In order to enable the Department, the General Assembly, and the public to monitor and evaluate the efficiency and effectiveness of each MCO, the Department shall engage an independent third party to perform an annual claims processing performance analysis of each MCO. The report of the first claims processing performance analysis shall be published by September 1, 2019, and every other year thereafter. The Department shall publish the report on its website.

(2) The MCO claims processing performance analysis shall evaluate each MCO's performance related to its processing of claims for payments and shall evaluate metrics that include, but are not limited to:

(A) claim rejections rates for clean and unclean claims and the top 10 reasons for rejections;

(B) claim denial rates, for clean and unclean claims and the top 10 reasons for denials;

(C) timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, 120, 150, and over 150 days, and the dollar amounts associated with those claims;

(D) a statistically valid sample of claims rejected, denied in whole or in part, or adjudicated greater than 30 days after original submission shall be

examined to determine the root cause for the rejection, denial, or untimely adjudication;

(E) the percentage of claims that were subject to payment of interest penalties;

(F) accuracy of claims payments, including applicable add-ons that are the responsibility of the MCO;

(G) number of claims disputes submitted to an appeals process and the number resulting in a payment or resolution in favor of the provider;

(H) percentage of claims disputes resolved through an appeals process;

(I) timeframe for completion of the appeals process;

(J) total dollar value paid to providers for claims resolved through an appeals process;

(K) total number and dollar amount of overpayment requests; and

(L) percentage of overpayment requests as a percentage of overall claims volume.

(3) The analysis under this Section shall, at a minimum, analyze and report on each MCO's claims processing of provider claims, and shall analyze and report on the performance by each type of provider separately.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already

designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16; 100-201, eff. 8-18-17.)

(305 ILCS 5/5-30.6 new)

Sec. 5-30.6. Managed care organization contracts procurement requirement. Beginning on the effective date of this amendatory Act of the 100th General Assembly, any new contract between the Department and a managed care organization as defined in Section 5-30.1 shall be procured in accordance with the Illinois Procurement Code.

(a) Application.

(1) This Section does not apply to the State of Illinois Medicaid Managed Care Organization Request for Proposals (2018-24-001) or any agreement, regardless of what it may be called, related to or arising from this procurement, including, but not limited to, contracts,

renewals, renegotiated contracts, amendments, and change orders.

(2) This Section does not apply to Medicare-Medicaid Alignment Initiative contracts executed under Article V-F of this Code.

(b) In the event any provision of this Section or of the Illinois Procurement Code is inconsistent with applicable federal law or would have the effect of foreclosing the use, potential use, or receipt of federal financial participation the applicable federal law or funding condition shall prevail, but only to the extent of such inconsistency.

(305 ILCS 5/5-30.7 new)

Sec. 5-30.7. Encounter data guidelines; provider fee schedule.

(a) No later than 60 days after the effective date of this amendatory Act of the 100th General Assembly, the Department shall publish on its website comprehensive written guidance on the submission of encounter data by managed care organizations. This information shall be updated and published as needed, but at least quarterly. The Department shall inform providers and managed care organizations of any updates via provider notices delivered at least 90 days prior to the effective date of any change.

(b) The Department shall publish on its website provider fee schedules on both a portable document format (PDF) and

EXCEL format. The portable document format shall serve as the ultimate source if there is a discrepancy.

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

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

Sec. 5A-2. Assessment.

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

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, or as provided in Section 5A-16, in addition

to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

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

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $XX multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2019 and 2020, a hospital's occupied bed

days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

Subject to Sections 5A-3 and 5A-10, for State fiscal years 2021 through 2024, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $XX multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however, that the amount of $XX used to calculate the assessment under this paragraph shall, by rule, be adjusted by a uniform percentage to generate the same total annual assessment that

was generated in State fiscal year 2020 from all hospitals subject to the annual assessment under this paragraph. For State fiscal years 2021 and 2022, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2017 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2019, without regard to any subsequent adjustments or changes to such data. For State fiscal years 2023 and 2024, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2019 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2021, without regard to any subsequent adjustments or changes to such data.

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, or as provided in Section 5A-16, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such

payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

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

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, or as provided in Section 5A-16, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without

regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to 0.XXXX multiplied by the hospital's outpatient gross revenue. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a

hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

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

(b-6)(1) As used in this Section, "ACA Assessment

Adjustment" means:

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

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

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under

subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2017 multiplied by 6, except that the amount calculated under this subparagraph (C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning January 1, 2017 through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subparagraph (B).

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

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

(ii) the amount calculated under this subparagraph

(D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments, if any, estimated to be paid to hospitals under subsection (b) of Section 5A-12.5.

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

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

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

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

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph (D)

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

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

(c) (Blank).

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

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall

be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

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

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

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

(a) The assessment imposed by Section 5A-2 for State fiscal

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

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

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

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

under Section 5A-12.6 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.6.

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

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

(c) If a hospital provider fails to pay the full amount of an installment when due (including any extensions granted under

subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5A-2 a penalty assessment equal to the lesser of (i) 5% of the amount of the installment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter or (ii) 100% of the installment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

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

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

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

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

(a) The Illinois Department shall send a notice of assessment to every hospital provider subject to assessment under this Article. The notice of assessment shall notify the

hospital of its assessment and shall be sent after receipt by the Department of notification from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services that the payment methodologies required under this Article and, if necessary, the waiver granted under 42 CFR 433.68 have been approved. The notice shall be on a form prepared by the Illinois Department and shall state the following:

(1) The name of the hospital provider.

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

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

(4) (Blank).

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

(b) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of

Public Health, the provider shall pay the assessment for each hospital separately.

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

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

(e) Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2018, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed

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

Notwithstanding any other provision in this Article, for State fiscal years 2019 through 2024, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in the year that is the basis of the calculation of the assessment under this Article, the assessment under paragraph (3) of subsection (a) of Section 5A-2 for the State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department, except that for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

Notwithstanding any other provision in this Article, for State fiscal years 2019 through 2024, in the case of a hospital provider that did not conduct, operate, or maintain a hospital

in the year that is the basis of the calculation of the assessment under this Article, the assessment under subsection (b-5) of Section 5A-2 for that State fiscal year shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Illinois Department, except that for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

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

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

(h) (Blank).

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

98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff. 7-20-15.)

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

Sec. 5A-8. Hospital Provider Fund.

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

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

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

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

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing activities under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health

Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

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

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

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

General Revenue Fund ..... $80,000,000.

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

(7.1) (Blank).

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

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

Healthcare Provider Relief Fund $100,000,000

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

The additional amount of transfers in this paragraph (7.10), authorized by Public Act 98-651, shall be made within 10 State business days after June 16, 2014 (the effective date of Public Act 98-651). That authority shall

remain in effect even if Public Act 98-651 does not become law until State fiscal year 2015.

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

Healthcare Provider Relief Fund $50,000,000

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

(7.11) (Blank).

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

Healthcare Provider Relief Fund $2,870,000

Since the federal Centers for Medicare and Medicaid

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

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

(7.14) For making transfers not exceeding the following amounts, related to State fiscal years 2019 through 2021, to the following designated funds:

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

Health Care Provider Relief Fund .. $325,000,000.

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

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

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

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

(c) The Fund shall consist of the following:

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

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

(3) Any interest or penalty levied in conjunction with

the administration of this Article.

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

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

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

(d) (Blank).

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

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

Sec. 5A-10. Applicability.

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

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

(2) For State fiscal years 2009 through 2018, <u>and as provided in Section 5A-16,</u> the Department of Healthcare and

Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008 except for:

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

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

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

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

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

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

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

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

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

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

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

provided in Section 5A-16, the Department reduces any payment rates to hospitals as in effect on May 1, 2012, or alters any payment methodology as in effect on May 1, 2012, that has the effect of reducing payment rates to hospitals, except for any changes affecting hospitals authorized in Public Act 97-689 and any changes authorized by Section 14-12 of this Code, and except for any changes authorized under Section 5A-15, and except for any changes authorized under Section 5-5b.1;

(2) for State fiscal years 2013 through 2018, and as provided in Section 5A-16, the Department reduces any supplemental payments made to hospitals below the amounts paid for services provided in State fiscal year 2011 as implemented by administrative rules adopted and in effect on or prior to June 30, 2011, except for any changes affecting hospitals authorized in Public Act 97-689 and any changes authorized by Section 14-12 of this Code, and except for any changes authorized under Section 5A-15, and except for any changes authorized under Section 5-5b.1; or

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

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

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

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

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

(305 ILCS 5/5A-12.5)

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

(a) The Department shall, subject to federal approval, mirror the Medical Assistance hospital reimbursement methodology for Affordable Care Act adults who are enrolled

under a fee-for-service or capitated managed care program, including hospital access payments as defined in Section 5A-12.2 of this Article and hospital access improvement payments as defined in Section 5A-12.4 of this Article, in compliance with the equivalent rate provisions of the Affordable Care Act.

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

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

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

(305 ILCS 5/5A-12.6 new)

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2018 the Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act. In determining the hospital access payments authorized under subsections (f) through (o) of this Section, unless otherwise specified, only Illinois hospitals shall be eligible for a payment and total Medicaid utilization statistics shall be used to determine the payment amount.

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

(1) For State fiscal years 2019 and 2020, up to

$630,000,000 of the total spending financed from the assessment authorized under Section 5A-2 that is intended to pay for hospital services and the hospital supplemental access payments authorized under subsections (d) and (f) of Section 14-12 for payment in State fiscal year 2018 may be used to increase claims-based hospital payment rates as specified under Section 14-12.

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

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

(4) For State fiscal years 2024, up to $1,663,000,000 of the total spending financed from the assessment authorized under Section 5A-2 that is intended to pay for

hospital services and the hospital supplemental access payments authorized under subsections (d) and (f) of Section 14-12 for payment in State Fiscal Year 2018 may be used to increase claims-based hospital payment rates as specified under Section 14-12.

(5) Beginning in State fiscal year 2021, and at least every 24 months thereafter, the Department shall, by rule, update the hospital access payments authorized under this Section to take into account the amount of funds being used to increase claims-based hospital payment rates under Section 14-12 and to apply the most recently available data and information, including data from the most recent base year and qualifying criteria which shall correlate to the updated base year data, to determine a hospital's eligibility for each payment and the amount of the payment authorized under this Section. Any updates of the hospital access payment methodologies shall not result in any diminishment of the aggregate amount of hospital access payment expenditures, except for reductions attributable to the use of such funds to increase claims-based hospital payment rates as authorized by this Section. Nothing in this Section shall be construed as precluding variations in the amount of any individual hospital's access payments. The Department shall publish the proposed rules to update the hospital access payments at least 90 days before their proposed effective date. The proposed rules shall not be

adopted using emergency rulemaking authority. The Department shall notify each hospital, in writing, of the impact of these updates on the hospital at least 30 calendar days prior to their effective date.

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

(d) Rate increase-based adjustment.

(1) From the funds financed by the assessment authorized under Section 5A-2, individual funding pools by category of service shall be established, for Inpatient General Acute Care services in the amount of $XX, Inpatient

Rehab Care services in the amount of $XX, Inpatient Psychiatric Care service in the amount of $XX, and Outpatient Care Services in the amount of $XX.

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

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

(4) As used in this subsection, "service credit factor" is determined based on a hospital's Rate Year 2017 Medicaid inpatient utilization rate ("MIUR"), as follows:

(A) Tier 1: A hospital with a MIUR equal to or greater than 75% shall have a service credit factor of 200%.

(B) Tier 2: A hospital with a MIUR equal to or greater than 33% but less than 75% shall have a service credit factor of 100%.

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

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

(e) Graduate medical education.

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

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

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

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

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

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

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

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

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

(2) Each critical access hospital that is not publicly owned shall be paid an outpatient high volume access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 outpatient EIS services and the denominator of which is the Fiscal Year 2015 outpatient EIS services for all hospitals eligible under this paragraph for this payment.

(3) Each tier 1 hospital that is not publicly owned shall be paid an outpatient high volume access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 outpatient EIS services and the denominator of which is the Fiscal Year 2015 outpatient EIS services for all hospitals

eligible under this paragraph for this payment. A tier 1 outpatient high volume hospital means a non-publicly owned hospital with total outpatient EIS services, equal to or greater than the regional mean plus one standard deviation for all hospitals in the region but less than the mean plus 1.5 standard deviation, or an Illinois non-publicly owned hospital with total outpatient EIS outpatient service units equal to or greater than the statewide mean plus one standard deviation.

(4) Each tier 2 hospital that is not publicly owned shall be paid an outpatient high volume access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 outpatient EIS services and the denominator of which is the Fiscal Year 2015 outpatient EIS services for all hospitals eligible under this paragraph for this payment. A tier 2 outpatient high volume hospital means a non-publicly owned hospital, excluding a safety-net hospital as defined in Section 5-5e.1 of this Code, with total outpatient EIS services equal to or greater than the regional mean plus 1.5 standard deviations for all hospitals in the region but less than the mean plus 2 standard deviations.

(5) Each tier 3 hospital that is not publicly owned shall be paid an outpatient high volume access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015

outpatient EIS services and the denominator of which is the Fiscal Year 2015 outpatient EIS services for all hospitals eligible under this paragraph for this payment. A tier 3 outpatient high volume hospital means a non-publicly owned hospital, excluding a safety-net hospital as defined in Section 5-5e.1 of this Code, with total outpatient EIS services equal to or greater than the regional mean plus 2 standard deviations for all hospitals in the region.

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

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

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

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

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

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

(A) Each tier 1 hospital shall be paid a Medicaid

dependent hospital access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment. A tier 1 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean but less than the statewide mean plus 0.5 standard deviation.

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

(C) Each tier 3 hospital shall be paid a Medicaid dependent hospital access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the

denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment. A tier 3 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus one standard deviation but less than the statewide mean plus 1.5 standard deviations.

(D) Each tier 4 hospital shall be paid a Medicaid dependent hospital access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment. A tier 4 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus 1.5 standard deviations but less than the statewide mean plus 2 standard deviations.

(E) Each tier 5 hospital shall be paid a Medicaid dependent hospital access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total days and the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for

this payment. A tier 5 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus 2 standard deviations.

(3) Each Medicaid high volume hospital shall be paid a Medicaid high volume access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment. A Medicaid high volume hospital means the Illinois general acute care hospitals with the highest number of Fiscal Year 2015 total admissions that when ranked in descending order from the highest Fiscal Year 2015 total admissions to the lowest Fiscal Year 2015 total admissions, in the aggregate, sum to at least 50% of the total admissions for all such hospitals in Fiscal Year 2015; however, any hospital which has qualified as a Medicaid dependent hospital shall not also be considered a Medicaid high volume hospital.

(i) Perinatal care access payment.

(1) Each Illinois non-publicly owned hospital designated a Level II or II+ perinatal center by the Department of Public Health as of December 1, 2017 shall be paid an access payment equal to $XX million multiplied by a

fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

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

(j) Trauma care access payment.

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

(2) Each Illinois non-publicly owned hospital designated a Level II trauma center by the Department of Public Health as of December 1, 2017 shall be paid an access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal

Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

(k) Perinatal and trauma center access payment.

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

(2) Each Illinois non-publicly owned hospital designated a Level II or II+ perinatal center and a Level I or II trauma center by the Department of Public Health as of December 1, 2017, and that has a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than 20% and a calendar year 2015 occupancy ratio equal to or greater than 50%, shall be paid an access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 total admissions and the denominator of which is the Fiscal Year 2015 total

admissions for all hospitals eligible under this paragraph for this payment.

(l) Long-term acute care access payment. Each Illinois non-publicly owned long-term acute care hospital that has a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than 25% and a calendar year 2015 occupancy ratio (as determined by the Department of Public Health based on the 2015 Annual Hospital Questionnaire) equal to or greater than 60% shall be paid an access payment equal to $XX million multiplied by a fraction, the numerator of which is the hospital's Fiscal Year 2015 general acute care admissions and the denominator of which is the Fiscal Year 2015 general acute care admissions for all hospitals eligible under this subsection for this payment.

(m) Small public hospital access payment.

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

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

(3) Each small public hospital shall be paid an outpatient access payment equal to $XX multiplied by a

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

(n) Psychiatric care access payment. In addition to rates paid for inpatient psychiatric services, the Illinois Department shall, by rule, establish an access payment for inpatient hospital psychiatric services that shall, in the aggregate, spend approximately $XX million annually. In consultation with the hospital community, the Department may, by rule, incorporate the funds used for this access payment to increase the payment rates for inpatient psychiatric services, except that such changes shall not take effect before July 1, 2019. Upon incorporation into the claims payment rates, this access payment shall be repealed.

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

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

"General acute care admissions" means, for a given hospital, the sum of inpatient hospital admissions provided to recipients of medical assistance under Title XIX of the Social

Security Act for general acute care, excluding admissions for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's paid claims data for general acute care admissions occurring during State fiscal year 2015 that was adjudicated by the Department through October 28, 2016.

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

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

"Total days" means, for a given hospital, the sum of inpatient hospital days provided to recipients of medical assistance under Title XIX of the Social Security Act for

general acute care, psychiatric care, and rehabilitation care, excluding days for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for total days occurring during State fiscal year 2015 that was adjudicated by the Department through October 28, 2016.

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

(q) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules that change the hospital access payments specified in this Section, but only to the extent necessary to conform to any federally approved amendment to the Title XIX State Plan. Any such rules shall be adopted by the Department as authorized by Section 5-50 of the Illinois Administrative Procedure Act. Notwithstanding any other provision of law, any changes implemented as a result of this subsection (q) shall be given

retroactive effect so that they shall be deemed to have taken effect as of the effective date of this amendatory Act of the 100th General Assembly.

(r) On or after July 1, 2018, and no less than annually thereafter, the Department shall increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in this Section to preserve access to hospital services for recipients under the Medical Assistance Program. The aggregate amount of all increased capitation payments to all MCOs for a fiscal year shall at least be the amount needed to avoid reduction in payments authorized under Section 5A-15. Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published by the Department each year. Managed care organizations and hospitals (including through their representative organizations), shall develop and implement methodologies and rates for payments that will preserve and improve access to hospital services for recipients in furtherance of the State's public policy to ensure equal access to covered services to recipients under the Medical Assistance Program. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments made under this subsection shall be guaranteed by a surety bond obtained by the

MCO in an amount established by the Department to approximate one month's liability of payments authorized under this subsection. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection.

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

(305 ILCS 5/5A-13)

Sec. 5A-13. Emergency rulemaking.

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

(b) The Department of Healthcare and Family Services may adopt rules necessary to implement this amendatory Act of the 97th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative

Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 97th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

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

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

(305 ILCS 5/5A-14)

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-15)

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

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

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

finding is made after payments have been issued, the payments under this Article that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the applicable federal upper payment limit; and

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

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

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

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

(305 ILCS 5/5A-16 new)

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

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

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

approved, then the reimbursement methodologies and payments to hospitals under Sections 5A-12.2, 5A-12.4, 5A-12.5, and 14-12, and the assessments imposed under Section 5A-2, as they are in effect on June 30, 2018, shall continue until the effective date of the new and revised methodologies and payments, which shall be the first day of the second month following the date of approval by the federal Centers for Medicare and Medicaid Services.

(305 ILCS 5/12-4.105)

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

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

(305 ILCS 5/14-12)

Sec. 14-12. Hospital rate reform payment system. The hospital payment system pursuant to Section 14-11 of this

Article shall be as follows:

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

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

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

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

(4) The Department shall develop add-on payments to account for exceptionally costly inpatient stays, consistent with Medicare outlier principles. Outlier fixed loss thresholds may be updated to control for excessive

growth in outlier payments no more frequently than on an annual basis, but at least triennially. Upon updating the fixed loss thresholds, the Department shall be required to update base rates within 12 months.

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

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

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

(7.5) Beginning July 1, 2020, the reimbursement for inpatient psychiatric services shall be so that base claims

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

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

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

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (1) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2020, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (2) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 40%. Beginning July 1, 2022, the statewide-standardized amount for inpatient general acute care services shall be uniformly increased so that base claims projected reimbursement is increased by an amount equal to the funds allocated in paragraph (3) of subsection

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

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

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

Beginning July 1, 2022, the reimbursement for inpatient rehabilitation services shall be uniformly increased so that the $96 per day add-on as adjusted by the July 1, 2020 increase, is increased by an amount equal to

the funds allocated in paragraph (3) of subsection (b) of Section 5A-12.6, less the amount allocated under paragraphs (8) and (9) of this subsection and paragraphs (3) and (4) of subsection (b) multiplied by 0.9%.

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

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

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

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

(A) The initial statewide standardized amounts,

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

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

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals. Beginning July 1, 2018, the outpatient high volume adjustor shall be increased to XX and this adjustor shall apply to public hospitals, except for large public hospitals, as defined under 89 Ill. Adm. Code 148.25(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) As provided in paragraph (9) of Section 3 of the Illinois Health Facilities Planning Act, any hospital participating in the transformation program may be exempt from the requirements of the Illinois Health Facilities Planning Act for those projects related to the hospital's transformation. To be eligible for an exemption, the hospital must submit to the Health Facilities and Services Review Board certification from the Department, approved by the Hospital Transformation Review Committee, that the project is a part of the hospital's transformation.

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

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

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

for approval only if the rule has first been approved by 7 of the 10 members of the Hospital Transformation Review Committee.

(4) Hospital Transformation Review Committee. There is created the Hospital Transformation Review Committee. The Committee shall consist of 10 members. No later than 30 days after the effective date of this amendatory Act of the 100th General Assembly, the Governor and the 4 legislative leaders shall each appoint 2 members. Any vacancy shall be filled by the applicable appointing authority within 15 calendar days. The members of the Committee shall select a Chair and a Vice-Chair from among its members, provided that the Chair and Co-Chair cannot be appointed by the same appointing authority and must be from different political parties. The Chair shall have the authority to establish a meeting schedule and convene meetings of the Committee, and the Vice-Chair shall have the authority to convene meetings in the absence of the Chair. The Committee may establish its own rules with respect to meeting schedule, notice of meetings, and the disclosure of documents; however, the Committee shall not have the power to subpoena individuals or documents and any rules must be approved by 7 of the 10 members. The Committee shall perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and

rules for the hospital transformation program, the Committee shall consider and make recommendations related to qualifying criteria and payment methodologies related to safety-net hospitals and children's hospitals. Members of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary.

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

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

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under

Section 5-5b.1, any updates to the system shall not result in any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors including but not limited to the number of individuals in the medical assistance program and the severity of illness of the individuals.

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

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559

(Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

(j) Out-of-state hospitals. The Department shall develop reimbursement methodologies to recognize the importance of out-of-state hospitals located in states that border Illinois and provide access to specialty hospital services, but only if such services are not reasonably available to beneficiaries from an Illinois hospital, or such hospital provides a significant volume of care. Effective July 1, 2018, for purposes of determining for State fiscal years 2019 and 2020 the hospitals eligible for the payments authorized under subsections (a) and (b) of this Section, the Department shall include children's hospitals located in St. Louis that are designated a Level III perinatal center by the Department of Public Health and also designated a Level I pediatric trauma center by the Department of Public Health as of December 1, 2017.

(k) Data sharing. The Department shall provide to the statewide association representing a majority of hospitals the data and information needed to perform data analyses related to potential hospital reimbursement methodologies, including, but

not limited to, those methodologies authorized under this Section and Article V-A of this Code. Such data shall include, but not be limited to, de-identified claims level data, any federal report annually required which identifies or evaluates the Medical Assistance Program's compliance with limits on spending, and any other data requested which can reasonably be considered necessary to develop, monitor, and evaluate the payment methodologies authorized in this Section. To the extent required by law, the release of such data may be subject to the execution of a data use agreement.

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

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

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

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