



Rep. Gregory Harris

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1 AMENDMENT TO SENATE BILL 1773

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

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

8 (5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

9 Sec. 5-45. Emergency rulemaking.

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

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

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

14 (c) An emergency rule may be effective for a period of not
15 longer than 150 days, but the agency's authority to adopt an
16 identical rule under Section 5-40 is not precluded. No
17 emergency rule may be adopted more than once in any 24-month
18 period, except that this limitation on the number of emergency
19 rules that may be adopted in a 24-month period does not apply
20 to (i) emergency rules that make additions to and deletions
21 from the Drug Manual under Section 5-5.16 of the Illinois
22 Public Aid Code or the generic drug formulary under Section
23 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii)
24 emergency rules adopted by the Pollution Control Board before
25 July 1, 1997 to implement portions of the Livestock Management
26 Facilities Act, (iii) emergency rules adopted by the Illinois

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

10 (c-5) To facilitate the maintenance of the program of group
11 health benefits provided to annuitants, survivors, and retired
12 employees under the State Employees Group Insurance Act of
13 1971, rules to alter the contributions to be paid by the State,
14 annuitants, survivors, retired employees, or any combination
15 of those entities, for that program of group health benefits,
16 shall be adopted as emergency rules. The adoption of those
17 rules shall be considered an emergency and necessary for the
18 public interest, safety, and welfare.

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

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

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

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

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

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

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

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

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

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

3 (k) In order to provide for the expeditious and timely
4 implementation of the provisions of the State's fiscal year
5 2006 budget, emergency rules to implement any provision of
6 Public Act 94-48 or any other budget initiative for fiscal year
7 2006 may be adopted in accordance with this Section by the
8 agency charged with administering that provision or
9 initiative, except that the 24-month limitation on the adoption
10 of emergency rules and the provisions of Sections 5-115 and
11 5-125 do not apply to rules adopted under this subsection (k).
12 The Department of Healthcare and Family Services may also adopt
13 rules under this subsection (k) necessary to administer the
14 Illinois Public Aid Code, the Senior Citizens and Persons with
15 Disabilities Property Tax Relief Act, the Senior Citizens and
16 Disabled Persons Prescription Drug Discount Program Act (now
17 the Illinois Prescription Drug Discount Program Act), and the
18 Children's Health Insurance Program Act. The adoption of
19 emergency rules authorized by this subsection (k) shall be
20 deemed to be necessary for the public interest, safety, and
21 welfare.

22 (l) In order to provide for the expeditious and timely
23 implementation of the provisions of the State's fiscal year
24 2007 budget, the Department of Healthcare and Family Services
25 may adopt emergency rules during fiscal year 2007, including
26 rules effective July 1, 2007, in accordance with this

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

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

22 (n) In order to provide for the expeditious and timely
23 implementation of the provisions of the State's fiscal year
24 2010 budget, emergency rules to implement any provision of
25 Public Act 96-45 or any other budget initiative authorized by
26 the 96th General Assembly for fiscal year 2010 may be adopted

1 in accordance with this Section by the agency charged with
2 administering that provision or initiative. The adoption of
3 emergency rules authorized by this subsection (n) shall be
4 deemed to be necessary for the public interest, safety, and
5 welfare. The rulemaking authority granted in this subsection
6 (n) shall apply only to rules promulgated during Fiscal Year
7 2010.

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

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

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

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

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

1 (s) In order to provide for the expeditious and timely
2 implementation of the provisions of Sections 5-5b.1 and 5A-2 of
3 the Illinois Public Aid Code, emergency rules to implement any
4 provision of Section 5-5b.1 or Section 5A-2 of the Illinois
5 Public Aid Code may be adopted in accordance with this
6 subsection (s) by the Department of Healthcare and Family
7 Services. The rulemaking authority granted in this subsection
8 (s) shall apply only to those rules adopted prior to July 1,
9 2015. Notwithstanding any other provision of this Section, any
10 emergency rule adopted under this subsection (s) shall only
11 apply to payments made for State fiscal year 2015. The adoption
12 of emergency rules authorized by this subsection (s) is deemed
13 to be necessary for the public interest, safety, and welfare.

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

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

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

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

18 (w) In order to provide for the expeditious and timely
19 implementation of the provisions of Public Act 99-796,
20 emergency rules to implement the changes made by Public Act
21 99-796 may be adopted in accordance with this subsection (w) by
22 the Adjutant General. The adoption of emergency rules
23 authorized by this subsection (w) is deemed to be necessary for
24 the public interest, safety, and welfare.

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

1 emergency rules to implement subsection (i) of Section 16-115D,
2 subsection (g) of Section 16-128A, and subsection (a) of
3 Section 16-128B of the Public Utilities Act may be adopted in
4 accordance with this subsection (x) by the Illinois Commerce
5 Commission. The rulemaking authority granted in this
6 subsection (x) shall apply only to those rules adopted within
7 180 days after June 1, 2017 (the effective date of Public Act
8 99-906). The adoption of emergency rules authorized by this
9 subsection (x) is deemed to be necessary for the public
10 interest, safety, and welfare.

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

24 (z) In order to provide for the expeditious and timely
25 implementation of the provisions of this amendatory Act of the
26 100th General Assembly, emergency rules to implement the

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

7 (aa) In order to provide for the expeditious and timely
8 initial implementation of the changes made to Articles 5, 5A,
9 12, and 14 of the Illinois Public Aid Code under the provisions
10 of this amendatory Act of the 100th General Assembly, the
11 Department of Healthcare and Family Services may adopt
12 emergency rules in accordance with this subsection (aa). The
13 24-month limitation on the adoption of emergency rules does not
14 apply to rules to initially implement the changes made to
15 Articles 5, 5A, 12, and 14 of the Illinois Public Aid Code
16 adopted under this subsection (aa). The adoption of emergency
17 rules authorized by this subsection (aa) is deemed to be
18 necessary for the public interest, safety, and welfare.

19 (Source: P.A. 99-2, eff. 3-26-15; 99-6, eff. 1-1-16; 99-143,
20 eff. 7-27-15; 99-455, eff. 1-1-16; 99-516, eff. 6-30-16;
21 99-642, eff. 7-28-16; 99-796, eff. 1-1-17; 99-906, eff. 6-1-17;
22 100-23, eff. 7-6-17; 100-554, eff. 11-16-17.)

23 (5 ILCS 100/5-46.3 new)

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

1 this Act, the Department of Healthcare and Family Services may
2 not file, the Secretary of State may not accept, and the Joint
3 Committee on Administrative Rules may not consider any rules
4 adopted in accordance to subsection (d-5) of Section 14-12 of
5 the Illinois Public Aid Code unless the rules have been
6 approved by 7 of the 10 members of the Hospital Transformation
7 Review Committee created under subsection (d-5) of Section
8 14-12 of the Illinois Public Aid Code. Approval of the rules
9 shall be demonstrated by submission of a written document
10 signed by each of the 7 approving members. The Department of
11 Healthcare and Family Services shall submit the written
12 document with signatures, along with a certified copy of each
13 rule, to the Secretary of State.

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

16 (20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (1) Federally-owned facilities.

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

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

1 facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

13 "Major medical equipment" means medical equipment which is
14 used for the provision of medical and other health services and
15 which costs in excess of the capital expenditure minimum,
16 except that such term does not include medical equipment
17 acquired by or on behalf of a clinical laboratory to provide
18 clinical laboratory services if the clinical laboratory is
19 independent of a physician's office and a hospital and it has
20 been determined under Title XVIII of the Social Security Act to
21 meet the requirements of paragraphs (10) and (11) of Section
22 1861(s) of such Act. In determining whether medical equipment
23 has a value in excess of the capital expenditure minimum, the
24 value of studies, surveys, designs, plans, working drawings,
25 specifications, and other activities essential to the
26 acquisition of such equipment shall be included.

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

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

1 to review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 (1) Federally-owned facilities.
- 2 (2) Facilities used solely for healing by prayer or
3 spiritual means.
- 4 (3) An existing facility located on any campus facility
5 as defined in Section 5-5.8b of the Illinois Public Aid
6 Code, provided that the campus facility encompasses 30 or
7 more contiguous acres and that the new or renovated
8 facility is intended for use by a licensed residential
9 facility.
- 10 (4) Facilities licensed under the Supportive
11 Residences Licensing Act or the Assisted Living and Shared
12 Housing Act.
- 13 (5) Facilities designated as supportive living
14 facilities that are in good standing with the program
15 established under Section 5-5.01a of the Illinois Public
16 Aid Code.
- 17 (6) Facilities established and operating under the
18 Alternative Health Care Delivery Act as a children's
19 community-based health care center alternative health care
20 model demonstration program or as an Alzheimer's Disease
21 Management Center alternative health care model
22 demonstration program.
- 23 (7) The closure of an entity or a portion of an entity
24 licensed under the Nursing Home Care Act, the Specialized
25 Mental Health Rehabilitation Act of 2013, the ID/DD
26 Community Care Act, or the MC/DD Act, with the exception of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 "Physician" means a person licensed to practice in

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

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

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

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

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

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

1 Ambulatory Surgical Treatment Center Act.

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

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

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

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

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

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

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

10 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
11 99-527, eff. 1-1-17; 100-518, eff. 6-1-18.)

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

14 (30 ILCS 500/1-10)

15 Sec. 1-10. Application.

16 (a) This Code applies only to procurements for which
17 bidders, offerors, potential contractors, or contractors were
18 first solicited on or after July 1, 1998. This Code shall not
19 be construed to affect or impair any contract, or any provision
20 of a contract, entered into based on a solicitation prior to
21 the implementation date of this Code as described in Article
22 99, including but not limited to any covenant entered into with
23 respect to any revenue bonds or similar instruments. All
24 procurements for which contracts are solicited between the

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

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

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

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

13 (3) Purchase of care, except as provided in Section
14 5-30.6 of the Illinois Public Aid Code and this Section.

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

19 (5) Collective bargaining contracts.

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

1 contract.

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

11 (8) (Blank).

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

14 (10) (Blank).

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

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

1 and are subject to Sections 5-30, 20-160, 50-13, 50-20,
2 50-35, and 50-37 of this Code, as well as the final
3 approval by the Board of the Illinois Finance Authority of
4 the terms of the contract.

5 (13) Contracts for services, commodities, and
6 equipment to support the delivery of timely forensic
7 science services in consultation with and subject to the
8 approval of the Chief Procurement Officer as provided in
9 subsection (d) of Section 5-4-3a of the Unified Code of
10 Corrections, except for the requirements of Sections
11 20-60, 20-65, 20-70, and 20-160 and Article 50 of this
12 Code; however, the Chief Procurement Officer may, in
13 writing with justification, waive any certification
14 required under Article 50 of this Code. For any contracts
15 for services which are currently provided by members of a
16 collective bargaining agreement, the applicable terms of
17 the collective bargaining agreement concerning
18 subcontracting shall be followed.

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

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

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

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

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

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

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

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

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

26 (f) (Blank).

1 (g) (Blank).

2 (h) This Code does not apply to the process to procure or
3 contracts entered into in accordance with Sections 11-5.2 and
4 11-5.3 of the Illinois Public Aid Code.

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

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

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

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

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

25 Section 10. The Emergency Medical Services (EMS) Systems

1 Act is amended by changing Section 32.5 as follows:

2 (210 ILCS 50/32.5)

3 Sec. 32.5. Freestanding Emergency Center.

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

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

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

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

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

21 (B) equipment standards; and

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

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

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

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

14 (7) (blank);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (b) The Department shall:

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

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

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

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

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

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

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

17 (305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

18 Sec. 5-5.02. Hospital reimbursements.

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

1 (1) For inpatient hospital services rendered, or if
2 applicable, for inpatient hospital discharges occurring,
3 on or after July 1, 1992 and on or before September 30,
4 1992, the Illinois Department shall reimburse hospitals
5 for inpatient services under the reimbursement
6 methodologies in effect for each hospital, and at the
7 inpatient payment rate calculated for each hospital, as of
8 June 30, 1992. For purposes of this paragraph,
9 "reimbursement methodologies" means all reimbursement
10 methodologies that pertain to the provision of inpatient
11 hospital services, including, but not limited to, any
12 adjustments for disproportionate share, targeted access,
13 critical care access and uncompensated care, as defined by
14 the Illinois Department on June 30, 1992.

15 (2) For the purpose of calculating the inpatient
16 payment rate for each hospital eligible to receive
17 quarterly adjustment payments for targeted access and
18 critical care, as defined by the Illinois Department on
19 June 30, 1992, the adjustment payment for the period July
20 1, 1992 through September 30, 1992, shall be 25% of the
21 annual adjustment payments calculated for each eligible
22 hospital, as of June 30, 1992. The Illinois Department
23 shall determine by rule the adjustment payments for
24 targeted access and critical care beginning October 1,
25 1992.

26 (3) For the purpose of calculating the inpatient

1 payment rate for each hospital eligible to receive
2 quarterly adjustment payments for uncompensated care, as
3 defined by the Illinois Department on June 30, 1992, the
4 adjustment payment for the period August 1, 1992 through
5 September 30, 1992, shall be one-sixth of the total
6 uncompensated care adjustment payments calculated for each
7 eligible hospital for the uncompensated care rate year, as
8 defined by the Illinois Department, ending on July 31,
9 1992. The Illinois Department shall determine by rule the
10 adjustment payments for uncompensated care beginning
11 October 1, 1992.

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

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

1 Security Act and qualified for the payments described in
2 subsection (c) of this Section for rate year 2014 provided
3 the hospital continues to meet the description in Section
4 1923(b) (1) (B) in the current determination year; or

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

10 (3) Illinois hospitals that on July 1, 1991 had a
11 Medicaid inpatient utilization rate, as defined in
12 paragraph (h) of this Section, that was at least the mean
13 Medicaid inpatient utilization rate for all hospitals in
14 Illinois receiving Medicaid payments from the Illinois
15 Department and which were located in a planning area with
16 one-third or fewer excess beds as determined by the Health
17 Facilities and Services Review Board, and that, as of June
18 30, 1992, were located in a federally designated Health
19 Manpower Shortage Area; or

20 (4) Illinois hospitals that:

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

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

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

5 (5) Any children's hospital, which means a hospital
6 devoted exclusively to caring for children. A hospital
7 which includes a facility devoted exclusively to caring for
8 children shall be considered a children's hospital to the
9 degree that the hospital's Medicaid care is provided to
10 children if either (i) the facility devoted exclusively to
11 caring for children is separately licensed as a hospital by
12 a municipality prior to February 28, 2013 or (ii) the
13 hospital has been designated by the State as a Level III
14 perinatal care facility, has a Medicaid Inpatient
15 Utilization rate greater than 55% for the rate year 2003
16 disproportionate share determination, and has more than
17 10,000 qualified children days as defined by the Department
18 in rulemaking.

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

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

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

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

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

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

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

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

8 (e) The inpatient adjustment payments described in
9 paragraphs (c) and (d) shall be increased on October 1, 1993
10 and annually thereafter by a percentage equal to the lesser of
11 (i) the increase in the DRI hospital cost index for the most
12 recent 12 month period for which data are available, or (ii)
13 the percentage increase in the statewide average hospital
14 payment rate over the previous year's statewide average
15 hospital payment rate. The sum of the inpatient adjustment
16 payments under paragraphs (c) and (d) to a hospital, other than
17 a county hospital (as defined in subsection (c) of Section 15-1
18 of this Code) or a hospital organized under the University of
19 Illinois Hospital Act, however, shall not exceed \$275 per day;
20 that limit shall be increased on October 1, 1993 and annually
21 thereafter by a percentage equal to the lesser of (i) the
22 increase in the DRI hospital cost index for the most recent
23 12-month period for which data are available or (ii) the
24 percentage increase in the statewide average hospital payment
25 rate over the previous year's statewide average hospital
26 payment rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (A) inpatient days;

4 (B) outpatient days;

5 (C) direct costs;

6 (D) indirect costs;

7 (E) managed care days;

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

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

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

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

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

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

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

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

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

18 (305 ILCS 5/5-5e.1)

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

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

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

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

1 (3) meets one of the following:

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

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

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

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

11 (2) "MIUR" means Medicaid Inpatient Utilization Rate
12 and is defined as a fraction, the numerator of which is the
13 number of a hospital's inpatient days provided in the
14 hospital's fiscal year ending 3 years prior to the rate
15 year, to patients who, for such days, were eligible for
16 Medicaid under Title XIX of the federal Social Security
17 Act, 42 USC 1396a et seq., excluding those persons eligible
18 for medical assistance pursuant to 42 U.S.C.
19 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
20 Section 5-2 of this Article, and the denominator of which
21 is the total number of the hospital's inpatient days in
22 that same period, excluding those persons eligible for
23 medical assistance pursuant to 42 U.S.C.
24 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of
25 Section 5-2 of this Article.

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

1 collection form, for the rate year.

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

4 (c) Beginning July 1, 2012 and ending on June 30, 2020
5 ~~2018~~, a hospital that would have qualified for the rate year
6 beginning October 1, 2011, shall be a Safety-Net Hospital.

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

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

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

18 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;
19 98-651, eff. 6-16-14.)

20 (305 ILCS 5/5-30.1)

21 Sec. 5-30.1. Managed care protections.

22 (a) As used in this Section:

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

1 "Emergency services" include:

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

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

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

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

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

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

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

1 a covered service in any of the following situations:

2 (1) the MCO authorized such services;

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

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

9 (4) the MCO could not be contacted; or

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

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

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

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

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

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

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

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

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

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

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

9 (D) the enrollee is discharged.

10 (f) Network adequacy and transparency.

11 (1) The Department shall:

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

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

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

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

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

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

4 (g) Timely payment of claims.

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

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

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

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

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

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

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

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

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

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

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

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

23 (A) the extension of the timely filing period;

24 (B) retroactive prior authorizations; and

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

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

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

5 (g-6) MCO Performance Metrics Report.

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

10 (A) claims payment, including timeliness and
11 accuracy;

12 (B) prior authorizations;

13 (C) grievance and appeals;

14 (D) utilization statistics;

15 (E) provider disputes;

16 (F) provider credentialing; and

17 (G) member and provider customer service.

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

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

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

1 Department.

2 (g-7) MCO claims processing performance analysis.

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

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

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

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

20 (C) timeliness of claims adjudication, which
21 identifies the percentage of claims adjudicated within
22 30, 60, 90, 120, 150, and over 150 days, and the dollar
23 amounts associated with those claims;

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

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

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

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

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

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

13 (I) timeframe for completion of the appeals
14 process;

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

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

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

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

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

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

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

11 (Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16;
12 100-201, eff. 8-18-17.)

13 (305 ILCS 5/5-30.6 new)

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

20 (a) Application.

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

1 renewals, renegotiated contracts, amendments, and change
2 orders.

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

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

12 (305 ILCS 5/5-30.7 new)

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

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

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

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

3 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

5 Sec. 5A-2. Assessment.

6 (a) (1) Subject to Sections 5A-3 and 5A-10, for State fiscal
7 years 2009 through 2018, or as long as continued under Section
8 5A-16, an annual assessment on inpatient services is imposed on
9 each hospital provider in an amount equal to \$218.38 multiplied
10 by the difference of the hospital's occupied bed days less the
11 hospital's Medicare bed days, provided, however, that the
12 amount of \$218.38 shall be increased by a uniform percentage to
13 generate an amount equal to 75% of the State share of the
14 payments authorized under Section 5A-12.5, with such increase
15 only taking effect upon the date that a State share for such
16 payments is required under federal law. For the period of April
17 through June 2015, the amount of \$218.38 used to calculate the
18 assessment under this paragraph shall, by emergency rule under
19 subsection (s) of Section 5-45 of the Illinois Administrative
20 Procedure Act, be increased by a uniform percentage to generate
21 \$20,250,000 in the aggregate for that period from all hospitals
22 subject to the annual assessment under this paragraph.

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

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

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

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

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

19 Subject to Sections 5A-3 and 5A-10, for State fiscal years
20 2021 through 2024, an annual assessment on inpatient services
21 is imposed on each hospital provider in an amount equal to \$XX
22 multiplied by the difference of the hospital's occupied bed
23 days less the hospital's Medicare bed days, provided however,
24 that the amount of \$XX used to calculate the assessment under
25 this paragraph shall, by rule, be adjusted by a uniform
26 percentage to generate the same total annual assessment that

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

15 (b) (Blank).

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

1 payments is required under federal law. For the period
2 beginning June 10, 2012 through June 30, 2012, the annual
3 assessment on outpatient services shall be prorated by
4 multiplying the assessment amount by a fraction, the numerator
5 of which is 21 days and the denominator of which is 365 days.
6 For the period of April through June 2015, the amount of
7 .008766 used to calculate the assessment under this paragraph
8 shall, by emergency rule under subsection (s) of Section 5-45
9 of the Illinois Administrative Procedure Act, be increased by a
10 uniform percentage to generate \$6,750,000 in the aggregate for
11 that period from all hospitals subject to the annual assessment
12 under this paragraph.

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

20 For the portion of State fiscal year 2012, beginning June
21 10, 2012 through June 30, 2012, and State fiscal years 2013
22 through 2018, or as provided in Section 5A-16, a hospital's
23 outpatient gross revenue shall be determined using the most
24 recent data available from each hospital's 2009 Medicare cost
25 report as contained in the Healthcare Cost Report Information
26 System file, for the quarter ending on June 30, 2011, without

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

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

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

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

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

1 Adjustment" means:

2 (A) For the period of July 1, 2016 through December 31,
3 2016, the product of .19125 multiplied by the sum of the
4 fee-for-service payments to hospitals as authorized under
5 Section 5A-12.5 and the adjustments authorized under
6 subsection (t) of Section 5A-12.2 to managed care
7 organizations for hospital services due and payable in the
8 month of April 2016 multiplied by 6.

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

23 (C) For the period of July 1, 2017 through December 31,
24 2017, the product of .19125 multiplied by the sum of the
25 fee-for-service payments to hospitals as authorized under
26 Section 5A-12.5 and the adjustments authorized under

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

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

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

26 (ii) the amount calculated under this subparagraph

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

5 (2) The Department shall complete and apply a final
6 reconciliation of the ACA Assessment Adjustment prior to June
7 30, 2018 to account for:

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

14 (B) any difference between the estimated
15 fee-for-service payments under subsection (b) of Section
16 5A-12.5 and the amount of such payments that are actually
17 scheduled to be paid.

18 The Department shall notify hospitals of any additional
19 amounts owed or reduction credits to be applied to the June
20 2018 ACA Assessment Adjustment. This is to be considered the
21 final reconciliation for the ACA Assessment Adjustment.

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

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

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

16 (c) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;
20 98-104, eff. 7-22-13.)

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

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

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

1 hospital of its assessment and shall be sent after receipt by
2 the Department of notification from the Centers for Medicare
3 and Medicaid Services of the U.S. Department of Health and
4 Human Services that the payment methodologies required under
5 this Article and, if necessary, the waiver granted under 42 CFR
6 433.68 have been approved. The notice shall be on a form
7 prepared by the Illinois Department and shall state the
8 following:

9 (1) The name of the hospital provider.

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

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

22 (4) (Blank).

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

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

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

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

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

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

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

11 Notwithstanding any other provision in this Article, for
12 State fiscal years 2019 through 2024, in the case of a hospital
13 provider that did not conduct, operate, or maintain a hospital
14 in the year that is the basis of the calculation of the
15 assessment under this Article, the assessment under paragraph
16 (3) of subsection (a) of Section 5A-2 for the State fiscal year
17 shall be computed on the basis of hypothetical occupied bed
18 days for the full calendar year as determined by the Illinois
19 Department, except that for a hospital provider that did not
20 have a 2015 Medicare cost report, but paid an assessment in
21 State fiscal year 2018 on the basis of hypothetical data, that
22 assessment amount shall be used for State fiscal years 2019 and
23 2020.

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

1 in the year that is the basis of the calculation of the
2 assessment under this Article, the assessment under subsection
3 (b-5) of Section 5A-2 for that State fiscal year shall be
4 computed on the basis of hypothetical gross outpatient revenue
5 for the full calendar year as determined by the Illinois
6 Department, except that for a hospital provider that did not
7 have a 2015 Medicare cost report, but paid an assessment in
8 State fiscal year 2018 on the basis of hypothetical data, that
9 assessment amount shall be used for State fiscal years 2019 and
10 2020.

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

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

25 (h) (Blank).

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

1 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.
2 7-20-15.)

3 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

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

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

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

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

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

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

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

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

18 (6.5) For making transfers to the Healthcare Provider
19 Relief Fund, except that transfers made under this
20 paragraph (6.5) shall not exceed \$60,000,000 in the
21 aggregate.

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

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

1 Long-Term Care Provider Fund \$30,000,000
 2 General Revenue Fund \$80,000,000.

3 Transfers under this paragraph shall be made within 7 days
 4 after the payments have been received pursuant to the
 5 schedule of payments provided in subsection (a) of Section
 6 5A-4.

7 (7.1) (Blank).

8 (7.5) (Blank).

9 (7.8) (Blank).

10 (7.9) (Blank).

11 (7.10) For State fiscal year 2014, for making transfers
 12 of the moneys resulting from the assessment under
 13 subsection (b-5) of Section 5A-2 and received from hospital
 14 providers under Section 5A-4 and transferred into the
 15 Hospital Provider Fund under Section 5A-6 to the designated
 16 funds not exceeding the following amounts in that State
 17 fiscal year:

18 Healthcare Provider Relief Fund \$100,000,000

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

23 The additional amount of transfers in this paragraph
 24 (7.10), authorized by Public Act 98-651, shall be made
 25 within 10 State business days after June 16, 2014 (the
 26 effective date of Public Act 98-651). That authority shall

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

3 (7.10a) For State fiscal years 2015 through 2018, for
4 making transfers of the moneys resulting from the
5 assessment under subsection (b-5) of Section 5A-2 and
6 received from hospital providers under Section 5A-4 and
7 transferred into the Hospital Provider Fund under Section
8 5A-6 to the designated funds not exceeding the following
9 amounts related to each State fiscal year:

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

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

15 (7.11) (Blank).

16 (7.12) For State fiscal year 2013, for increasing by
17 21/365ths the transfer of the moneys resulting from the
18 assessment under subsection (b-5) of Section 5A-2 and
19 received from hospital providers under Section 5A-4 for the
20 portion of State fiscal year 2012 beginning June 10, 2012
21 through June 30, 2012 and transferred into the Hospital
22 Provider Fund under Section 5A-6 to the designated funds
23 not exceeding the following amounts in that State fiscal
24 year:

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

26 Since the federal Centers for Medicare and Medicaid

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

12 (7.13) In addition to any other transfers authorized
 13 under this Section, for State fiscal years 2017 and 2018,
 14 for making transfers to the Healthcare Provider Relief Fund
 15 of moneys collected from the ACA Assessment Adjustment
 16 authorized under subsections (a) and (b-5) of Section 5A-2
 17 and paid by hospital providers under Section 5A-4 into the
 18 Hospital Provider Fund under Section 5A-6 for each State
 19 fiscal year. Timing of transfers to the Healthcare Provider
 20 Relief Fund under this paragraph shall be at the discretion
 21 of the Department, but no less frequently than quarterly.

22 (7.14) For making transfers not exceeding the
 23 following amounts, related to State fiscal years 2019
 24 through 2021, to the following designated funds:

25	<u>Health and Human Services Medicaid Trust</u>	
26	<u>Fund</u>	<u>\$20,000,000</u>

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

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

3 Transfers under this paragraph shall be made within 7
4 days after the payments have been received pursuant to the
5 schedule of payments provided in subsection (a) of Section
6 5A-4.

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

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

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

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

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

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

26 (3) Any interest or penalty levied in conjunction with

1 the administration of this Article.

2 (3.5) As applicable, proceeds from surety bond
3 payments payable to the Department as referenced in
4 subsection (s) of Section 5A-12.2 of this Code.

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

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

9 (d) (Blank).

10 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;
11 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 99-78, eff.
12 7-20-15; 99-516, eff. 6-30-16; 99-933, eff. 1-27-17; revised
13 2-15-17.)

14 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

15 Sec. 5A-10. Applicability.

16 (a) The assessment imposed by subsection (a) of Section
17 5A-2 shall cease to be imposed and the Department's obligation
18 to make payments shall immediately cease, and any moneys
19 remaining in the Fund shall be refunded to hospital providers
20 in proportion to the amounts paid by them, if:

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

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

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

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

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

10 (C) any changes proposed in State plan amendment
11 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
12 08-07;

13 (D) in relation to any admissions on or after
14 January 1, 2011, a modification in the methodology for
15 calculating outlier payments to hospitals for
16 exceptionally costly stays, for hospitals reimbursed
17 under the diagnosis-related grouping methodology in
18 effect on July 1, 2011; provided that the Department
19 shall be limited to one such modification during the
20 36-month period after the effective date of this
21 amendatory Act of the 96th General Assembly;

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

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

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

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

13 (c) The assessments imposed by subsection (b-5) of Section
14 5A-2 shall not take effect or shall cease to be imposed, the
15 Department's obligation to make payments shall immediately
16 cease, and any moneys remaining in the Fund shall be refunded
17 to hospital providers in proportion to the amounts paid by
18 them, if the payments to hospitals required under Section
19 5A-12.4 or Section 5A-12.6 are not eligible for federal
20 matching funds under Title XIX of the Social Security Act.

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

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

1 provided in Section 5A-16, the Department reduces any
2 payment rates to hospitals as in effect on May 1, 2012, or
3 alters any payment methodology as in effect on May 1, 2012,
4 that has the effect of reducing payment rates to hospitals,
5 except for any changes affecting hospitals authorized in
6 Public Act 97-689 and any changes authorized by Section
7 14-12 of this Code, and except for any changes authorized
8 under Section 5A-15, and except for any changes authorized
9 under Section 5-5b.1;

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

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

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

7 (1) the payments to hospitals required under Section
8 5A-12.6 are not eligible for federal matching funds under
9 Title XIX of the Social Security Act; or

10 (2) the Department reduces the overall effective rate
11 of reimbursement to hospitals below the level authorized
12 under Section 14-12 of this Code, as in effect on December
13 31, 2017, except for any changes authorized under Sections
14 14-12 or Section 5A-15 of this Code, and except for any
15 changes authorized under changes to Sections 5A-12.2,
16 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by this
17 amendatory Act of the 100th General Assembly.

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

20 (305 ILCS 5/5A-12.5)

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

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

1 under a fee-for-service or capitated managed care program,
2 including hospital access payments as defined in Section
3 5A-12.2 of this Article and hospital access improvement
4 payments as defined in Section 5A-12.4 of this Article, in
5 compliance with the equivalent rate provisions of the
6 Affordable Care Act.

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

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

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

23 (305 ILCS 5/5A-12.6 new)

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

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

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

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

1 \$630,000,000 of the total spending financed from the
2 assessment authorized under Section 5A-2 that is intended
3 to pay for hospital services and the hospital supplemental
4 access payments authorized under subsections (d) and (f) of
5 Section 14-12 for payment in State fiscal year 2018 may be
6 used to increase claims-based hospital payment rates as
7 specified under Section 14-12.

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

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

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

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

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

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

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

22 (d) Rate increase-based adjustment.

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

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

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

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

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

4 (A) Tier 1: A hospital with a MIUR equal to or
5 greater than 75% shall have a service credit factor of
6 200%.

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

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

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

15 (e) Graduate medical education.

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

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

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

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

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

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

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

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

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

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

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

1 eligible under this paragraph for this payment. A tier 1
2 outpatient high volume hospital means a non-publicly owned
3 hospital with total outpatient EIS services, equal to or
4 greater than the regional mean plus one standard deviation
5 for all hospitals in the region but less than the mean plus
6 1.5 standard deviation, or an Illinois non-publicly owned
7 hospital with total outpatient EIS outpatient service
8 units equal to or greater than the statewide mean plus one
9 standard deviation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (i) Perinatal care access payment.

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

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

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

13 (j) Trauma care access payment.

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

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

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

4 (k) Perinatal and trauma center access payment.

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

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

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

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

14 (m) Small public hospital access payment.

15 (1) As used in this subsection, "small public hospital"
16 means any Illinois publicly owned hospital which is not a
17 "large public hospital" as described in 89 Ill. Adm. Code
18 148.25(a).

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

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

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

6 (n) Psychiatric care access payment. In addition to rates
7 paid for inpatient psychiatric services, the Illinois
8 Department shall, by rule, establish an access payment for
9 inpatient hospital psychiatric services that shall, in the
10 aggregate, spend approximately \$XX million annually. In
11 consultation with the hospital community, the Department may,
12 by rule, incorporate the funds used for this access payment to
13 increase the payment rates for inpatient psychiatric services,
14 except that such changes shall not take effect before July 1,
15 2019. Upon incorporation into the claims payment rates, this
16 access payment shall be repealed.

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

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

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

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

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

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

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

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

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

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

1 retroactive effect so that they shall be deemed to have taken
2 effect as of the effective date of this amendatory Act of the
3 100th General Assembly.

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

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

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

11 (305 ILCS 5/5A-13)

12 Sec. 5A-13. Emergency rulemaking.

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

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

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

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

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

1 (305 ILCS 5/5A-14)

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

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

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

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

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

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

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

10 (Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12;
11 98-651, eff. 6-16-14.)

12 (305 ILCS 5/5A-15)

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

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

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

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

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

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

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

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

17 (305 ILCS 5/5A-16 new)

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

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

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

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

9 (305 ILCS 5/12-4.105)

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

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

22 (305 ILCS 5/14-12)

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

1 Article shall be as follows:

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

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

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

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

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

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

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

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

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

25 (7.5) Beginning July 1, 2020, the reimbursement for
26 inpatient psychiatric services shall be so that base claims

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

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

1 (9) Beginning July 1, 2018, in addition to the
2 statewide-standardized amount, the Department shall apply
3 the same adjustor that is applied to trauma cases as of
4 December 31, 2017 to inpatient claims to treat patients
5 with burns, including, but not limited to, APR-DRGs 841,
6 842, 843, and 844.

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

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

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

15 Beginning July 1, 2020, the reimbursement for
16 inpatient rehabilitation services shall be uniformly
17 increased so that the \$96 per day add-on is increased by an
18 amount equal to the funds allocated in paragraph (2) of
19 subsection (b) of Section 5A-12.6, less the amount
20 allocated under paragraphs (8) and (9) of this subsection
21 and paragraphs (3) and (4) of subsection (b) multiplied by
22 0.9%.

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

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

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

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

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

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

26 (A) The initial statewide standardized amounts,

1 with the labor portion adjusted by the Calendar Year
2 2013 Medicare Outpatient Prospective Payment System
3 wage index with reclassifications, shall be published
4 by the Department on its website no later than 10
5 calendar days prior to their effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (j) Out-of-state hospitals. The Department shall develop
9 reimbursement methodologies to recognize the importance of
10 out-of-state hospitals located in states that border Illinois
11 and provide access to specialty hospital services, but only if
12 such services are not reasonably available to beneficiaries
13 from an Illinois hospital, or such hospital provides a
14 significant volume of care. Effective July 1, 2018, for
15 purposes of determining for State fiscal years 2019 and 2020
16 the hospitals eligible for the payments authorized under
17 subsections (a) and (b) of this Section, the Department shall
18 include children's hospitals located in St. Louis that are
19 designated a Level III perinatal center by the Department of
20 Public Health and also designated a Level I pediatric trauma
21 center by the Department of Public Health as of December 1,
22 2017.

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

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

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

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

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

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