Sen. Kimberly A. Lightford

Filed: 5/30/2026

AMENDMENT TO SENATE BILL 599

AMENDMENT NO. _____. Amend Senate Bill 599 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Safety-Net Hospital Access Act.

Section 5. Purpose.

(a) The purpose of this Act is to ensure that the State of Illinois maintains a hospital safety-net system with the capacity to guarantee equitable access to emergency, maternal, pediatric, behavioral health, and specialist care services for all low-income, uninsured, and Medicaid-enrolled residents, irrespective of race, ethnicity, geographic location, socioeconomic status, or insurance status. To accomplish that objective, this Act creates a method of funding Safety-Net Hospital operations that is:

(1) evidence-based;

(2) sufficient to ensure every qualifying institution can sustain minimum viable operations; and

(3) sustainable and predictable.

(b) When fully funded under this Act, every qualifying Safety-Net Hospital shall have resources, based on what the evidence indicates is needed:

(1) to provide all Medicaid-enrolled and uninsured patients with access to emergency, ambulatory, specialist, maternal, pediatric, and behavioral health services that will allow them to achieve and maintain health outcomes consistent with the general population of this State;

(2) to ensure all vulnerable patients served receive the care they need to avoid preventable hospitalizations, emergency department dependency, and premature mortality;

(3) to reduce, with the goal of eliminating, health disparities between low-income populations and the general population by raising the quality and accessibility of safety-net services rather than by reducing standards of care; and

(4) to ensure this State satisfies its obligation to support institutions that provide a disproportionate share of uncompensated care and simultaneously relieve the structural financial burden that makes Safety-Net Hospital status genuinely precarious.

Section 10. Definitions. As used in this Act:

"Access gap remediation" means reducing disparities in the availability of specialist, emergency, maternal, pediatric, and behavioral health services in communities served by qualifying Safety-Net Hospitals.

"Adequacy target" means the formula-derived minimum funding level sufficient for a qualifying institution to deliver the access services for which it qualifies under this Act.

"Allocation rate" means the percentage share of the total Safety-Net Hospital Access Fund pool allocated to a qualifying institution.

"Ancillary visit volume" means the total annual laboratory, diagnostic imaging, physical therapy, occupational therapy, and speech therapy visits delivered to Medicaid-enrolled and uninsured patients at a qualifying institution, as reported through State all-payer claims or CMS cost reports (HCRIS).

"Annual change cap" means the constraint, effective beginning in Fiscal Year 2031, that limits any qualifying institution's year-over-year allocation change to plus or minus 3% relative to the prior fiscal year's allocation.

"At-risk population" means Medicaid-enrolled patients, uninsured patients, and patients receiving charity care or services payable under the Disproportionate Share Hospital Program, as defined under applicable federal and State law.

"Behavioral health" or "BH" means mental health and

substance use disorder (SUD) services, including crisis intervention, inpatient psychiatric care, outpatient counseling, and medication-assisted treatment, as recognized by SAMHSA and the Department of Human Services.

"BH/SUD service integration" means the degree to which a qualifying institution has embedded behavioral health and substance use disorder services into its emergency department and inpatient settings, scored on a tiered scale of 0 (no integration), 1 (partial integration), or 2 (full integration across both ED and inpatient settings).

"Ceiling allocation" means the maximum permissible allocation to any single qualifying institution in a given fiscal year, set at 12% of the total Safety-Net Hospital Access Fund pool.

"CMS" means the Centers for Medicare and Medicaid Services.

"CMS cost reports (HCRIS)" means the Healthcare Cost Report Information System maintained by CMS, containing cost and utilization data submitted annually by participating hospitals.

"Cohort median fallback" means the scoring methodology applied when a qualifying institution is unable to supply complete data for a criterion. An institution shall receive the cohort median z-score for this criterion in lieu of a zero, preventing data gaps from producing punitive allocations.

"Composite index score" means the aggregated, weighted

score for a qualifying institution computed pursuant to the 5-step formula methodology in Section 25, representing that institution's relative standing across all 4 domains.

"Data refresh cycle" means the annual update of criterion-level data inputs used in the formula calculation, applying 3-year rolling averages where available.

"Department" means the Department of Healthcare and Family Services or its successor agency.

"Disbursement schedule" means the quarterly disbursement of each institution's annual allocation in 4 equal installments, contingent on continued reporting compliance.

"Domain" means one of the 4 weighted categories of criteria used in the formula. Domain 1 is the Specialist Access Enhancement Domain. Domain 2 is the Emergency and Ambulatory Care Access Domain. Domain 3 is the Obstetrics, Pediatric, and Behavioral Health Access Domain. Domain 4 is the Structural Financial Vulnerability Domain.

"Domain score" means the sum of the weighted z-scores for all criteria within a given domain, computed pursuant to Step 2 of the formula methodology.

"DSH" means Disproportionate Share Hospital payments made pursuant to Section 1923 of the Social Security Act and applicable State Medicaid plan provisions.

"ED boarding hours" means the total annual hours patients spend in the emergency department of a qualifying institution pending inpatient bed placement, as reported through State ED

surveillance data or Joint Commission quality data.

"Emergency department" or "ED" means the organized hospital-based facility that provides unscheduled episodic services to patients who present for immediate medical attention.

"Evidence-based funding" means State funding provided to a qualifying institution pursuant to this Section, governed by the 4-domain weighted index formula.

"Fiscal Year 2026 baseline allocation" means each qualifying institution's approved safety-net funding allocation for fiscal year 2026 as established by the General Assembly, which serves as the basis for Fiscal Year 2027 transition amounts.

"Fiscal Year 2027 transition allocation" means each qualifying institution's initial allocation under this Act, calculated by applying the institution's Fiscal Year 2026 percentage share of the Fiscal Year 2026 total funding pool to the Fiscal Year 2027 total funding pool.

"Floor allocation" means the minimum permissible allocation to any single qualifying institution in a given fiscal year set at $5,000,000.

"Formula governance period" means the period beginning in Fiscal Year 2031 during which annual allocations are determined by the 4-domain formula subject to the annual change cap.

"FQHC" means a Federally-Qualified Health Center, as

designated by the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Service Act.

"FQHC affiliation" means a formal or informal relationship between a qualifying institution and one or more FQHCs, scored on a tiered scale of 0 (no relationship), 1 (informal memorandum of understanding or data-sharing agreement), or 2 (formal affiliation or co-location with shared care coordination).

"HPSA" means Health Professional Shortage Area, as designated by the HRSA under Section 332 of the Public Health Service Act.

"HRSA" means the Health Resources and Services Administration of the United States Department of Health and Human Services.

"Independent NFP status" means the degree of institutional independence from health system affiliation, scored on a tiered scale of 0 (full health system affiliation), 1 (partial affiliation or management agreement), or 2 (fully independent not-for-profit community hospital without controlling entity affiliation).

"Independent Technical Advisory Panel" or "ITAP" means the panel of independent technical experts established under this Act to conduct sensitivity analysis, equity review, and annual recalibration of the formula.

"Inverse scoring" means the methodology applied to metrics where worse performance or greater community need produces a

higher score, achieved by negating the z-score before weighting.

"Low-birth-weight rate" means the percentage of live births below 2,500 grams occurring in the primary zip code catchment area of a qualifying institution's service area, as reported by the Department of Public Health or State vital statistics records.

"LWBS rate" means the left-without-being-seen rate, the percentage of emergency department patients who leave without being seen by a provider, as reported through State ED surveillance data.

"Medicaid and Uninsured Payer Mix Percentage" or "MIUR" means the sum of Medicaid inpatient days and indigent inpatient days divided by total adjusted patient days for a qualifying institution, consistent with CMS DSH methodology, as reported in CMS cost reports (HCRIS).

"Qualifying institution" means a hospital that (i) was included on the General Assembly-approved Safety-Net Hospital funding list for fiscal year 2026; (ii) has not permanently closed prior to the applicable fiscal year; and (iii) has not been removed from eligibility by action of the Department under this Act.

"Referral capture rate" means the percentage of specialist referrals initiated by a qualifying institution that are completed within the institution or its community network within a specified time period, as reported through State

all-payer claims or self-report on unmet or delayed referrals.

"Rolling average" means the 3-year rolling average of annual criterion data used in the formula calculation to smooth year-to-year volatility.

"Safety-Net Hospital" means a hospital that provides a disproportionate share of care to Medicaid-enrolled, uninsured, and other vulnerable patients, consistent with the criteria established under this Act and applicable federal Medicaid law.

"Safety-Net Hospital Access Fund" means the State fund from which allocations to qualifying institutions are disbursed pursuant to this Act.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services.

"Specialist-to-population ratio" means the number of specialist physicians per 10,000 residents in the primary zip code catchment area of a qualifying institution's service area, as reported by HRSA Health Workforce Data and the AMA Masterfile.

"Stabilization period" means Fiscal Years 2028, 2029, and 2030, during which each qualifying institution's Fiscal Year 2027 allocation is held flat to provide budget certainty while formula operationalization is completed.

"Total funding pool" means the annual appropriation to the Safety-Net Hospital Access Fund.

"Uncompensated care" means the sum of charity care and bad debt borne by a qualifying institution on behalf of patients who cannot pay, expressed as a percentage of gross patient revenue, as reported in CMS cost reports (HCRIS) or audited financial statements.

"Z-score normalization" means the statistical transformation of a raw criterion value into a standardized score representing the distance of the institution's value from the cohort mean, expressed in units of cohort standard deviation, where z is equal to the difference between the hospital value and the cohort mean, divided by the cohort standard deviation.

Section 15. Safety-Net Hospital Access Fund.

(a) The Safety-Net Hospital Access Fund is created as a special fund in the State treasury to be administered by the Department. The Department shall allocate moneys in the Fund to qualifying institutions in accordance with this Act.

(b) A qualifying institution may apply allocations from the Safety-Net Hospital Access Fund under this Act to any lawful purpose consistent with its mission, including, but not limited to:

(1) staffing and personnel costs;

(2) capital improvements;

(3) technology acquisition; and

(4) patient access programs.

Section 20. Transition and stabilization rules.

(a) The Fiscal Year 2027, Fiscal Year 2028, Fiscal Year 2029, and Fiscal Year 2030 allocations are calculated by applying an institution's percentage share of the $114,000,000 total funding pool in Fiscal Year 2026 to the total funding pool for the applicable Fiscal Year.

(b) For Fiscal Year 2031 and each fiscal year thereafter, annual allocations are governed by the 4-domain formula. Year-over-year changes are capped at 3% in either direction to prevent acute funding disruptions.

Section 25. Funding allocation methodology. For Fiscal Year 2031 and each fiscal year thereafter, annual allocations to qualifying institutions under this Act are governed by an evidence-based funding formula, which shall be calculated through the following sequential steps:

Step 1: Score each criterion by converting raw values, including percentages, counts, and ratios, into a common scale. For inversely scored metrics (referral capture rate, ED boarding hours, LWBS rate, low-birth-weight rate), negate the z-score so that worse performance or greater community need produces a higher score.

Step 2: Compute domain scores by calculating the sum of the products of the criterion weights multiplied by the z-scores for all criteria within a given domain. Domain

scores are not re-normalized at this stage. They carry the natural scale of the z-score distribution.

Step 3: Compute the composite index by calculating the total sum of each domain score multiplied by the assigned domain weight, plus a base of 100. The result is a single comparable index value for each qualifying institution.

Step 4: Apply floor and ceiling constraints by converting the composite index to a preliminary allocation percentage. Apply the floor (minimum 4.5% plus $5,000,000 minimum base) and ceiling (maximum 12%) to each institution's preliminary share. These constraints shall prevent any institution from being effectively zeroed out or from capturing a disproportionate share of the pool.

Step 5: Normalize to 100% and apply to the Fund. The final share, expressed as a percentage, shall be the quotient of an individual institution's preliminary share divided by the sum total of all preliminary shares. The final dollar allocation shall be the product of the final share multiplied by the total funding pool. Funds shall be disbursed quarterly in equal installments, contingent on reporting compliance.

Section 30. Domain weights and criteria.

(a) The Department shall assign up to 25 points for Domain 1: the Specialist Access Enhancement Domain. This domain addresses the structural deficit in specialist care

availability facing communities served by Safety-Net Hospitals. It measures both the supply-side gap in specialist availability and whether existing referral pathways are successfully connecting patients to specialist services. The FQHC affiliation criterion rewards institutions that have built formal coordination infrastructure into primary care safety-net settings, extending their access reach beyond their own walls. The 25 points for Domain 1 shall be assigned using the following criteria:

(1) up to 12 points for the specialist-to-population ratio in the service area, with those areas with a higher gap receiving a higher score;

(2) up to 8 points for the referral capture rate, with lower capture rates receiving a higher score; and

(3) up to 5 points for FQHC affiliation, with higher tiers receiving higher scores.

(b) The Department shall assign up to 25 points for Domain 2: the Emergency and Ambulatory Care Access Domain. This domain measures the emergency department's role as both a primary acute care access point and a broader ambulatory safety-net for Medicaid and uninsured patients. ED visit volume anchors the domain as the primary access signal, with ancillary and outpatient specialist volume capturing the breadth of access delivery beyond the ED itself. Boarding hours and LWBS rate provide a capacity stress signal. The 25 points for Domain 2 shall be assigned using the following

criteria:

(1) up to 12 points for the total number of ED visits by Medicaid patients and uninsured patients, assessed using State ED surveillance data and CMS cost reports (HCRIS), with a higher number of ED visits receiving a higher score;

(2) up to 5 points for ancillary visit volume, with a higher number of ancillary visits receiving a higher score;

(3) up to 3 points for the total number of outpatient specialist visits by Medicaid patients and uninsured patients, assessed using State all-payer claims and CMS cost reports (HCRIS), with a higher number of outpatient specialist visits receiving a higher score;

(4) up to 3 points for ED boarding hours, with a higher number of ED boarding hours receiving a higher score; and

(5) up to 2 points for LWBS rate, with a higher LWBS rate receiving a higher score.

(c) The Department shall assign up to 30 points for Domain 3: the Obstetrics, Pediatric, and Behavioral Health Access Domain. This domain carries the greatest weight in the framework because it targets the 3 service lines where access deserts are most severe, closure risk is highest, and the populations affected, mothers, children, and individuals with behavioral health needs, are the most vulnerable. Data sources span the Department of Public Health, State all-payer claims,

and SAMHSA program databases, all of which are publicly verifiable. The 30 points for Domain 3 shall be assigned using the following criteria:

(1) up to 5 points for the total number of obstetrics deliveries by Medicaid patients and uninsured patients, assessed using State all-payer claims and UB-04 data, with a higher number of obstetrics deliveries receiving a higher score;

(2) up to 5 points for the low-birth-weight rate in the service area, with higher rates receiving a higher score; and

(3) up to 10 points for the total annual inpatient discharges for patients under 18 years of age, assessed using State all-payer claims and CMS cost reports (HCRIS), with a higher number of inpatient discharges receiving a higher score;

(4) up to 7 points for BH/SUD service integration, assessed using HFS/SAMHSA treatment locator data, State licensing data, and facility attestations, with higher tiers receiving a higher score; and

(5) up to 3 points for BH outpatient visits by Medicaid patients and uninsured patients, assessed using State all-payer claims and SAMHSA data, with higher BH outpatient visit volumes receiving a higher score.

(d) The Department shall assign up to 20 points for Domain 4: the Structural Financial Vulnerability Domain. This domain

targets the structural funding disadvantages that make safety-net status genuinely precarious, high Medicaid and uninsured payer mix, uncompensated care burden, independence from health system cross-subsidization, and geographic isolation. The Medicaid and Uninsured Payer Mix Percentage anchors the domain at nearly half its total weight as the most direct and auditable proxy for payer mix burden. The 20 points for Domain 4 shall be assigned using the following criteria:

(1) up to 8 points for the Medicaid and Uninsured Payer Mix Percentage, with a higher percentage receiving a higher score; and

(2) up to 4 points for uncompensated care, with a higher percentage receiving a higher score; and

(3) up to 4 points for independent NFP status, assessed using State hospital licensing data and IRS Form 990 data, with a higher tier receiving a higher score; and

(4) up to 4 points for Rural, HRSA or HPSA, or independent safety-net status, assessed using HRSA data and CMS designation records, scored on a tiered scale of 0 (urban or no designation), 1 (HRSA designation, HPSA designation, or rural location), or 2 (independent Safety-Net Hospital not controlled by another entity with assets exceeding $750,000,000), with higher tiers receiving a higher score.

Section 35. Independent Technical Advisory Panel.

(a) On or before January 1, 2027, the Department shall establish an Independent Technical Advisory Panel that shall consist of not fewer than 5 members with demonstrated expertise in hospital finance, public health, health equity, or health care data analytics. Panel members shall serve staggered 3-year terms and shall be subject to conflict-of-interest disclosure requirements established by the Department.

(b) Before Fiscal Year 2031 formula-based allocations are finalized, a formal data availability review shall be conducted by the Department, in consultation with the Independent Technical Advisory Panel, across the qualifying cohort.

(c) The Independent Technical Advisory Panel shall conduct a formal sensitivity analysis to test whether small changes in domain weights materially alter the distribution ranking before the formula under Section 25 is adopted. The Panel shall publish the results of the sensitivity analysis with a public notice and comment period of not less than 30 days.

(d) Prior to each annual distribution cycle beginning in Fiscal Year 2031, the Independent Technical Advisory Panel shall prepare a demographic disparity analysis showing whether formula allocations align with the geographic distribution of the most vulnerable populations served by qualifying institutions. The equity review shall be published for public comment not less than 60 days before allocations are

finalized.

Section 40. Grievances. Not less than 90 days before the first formula-based scoring cycle, the Department shall establish and publish a grievance process that allows qualifying institutions to challenge data errors, not formula weights or methodology choices, within 30 days after receiving preliminary score notifications.

Section 80. Rulemaking. The Department, in consultation with the Independent Technical Advisory Panel established under Section 40, may adopt any rules necessary to implement and administer this Act.

Section 90. The State Finance Act is amended by adding Section 5.1038 as follows:

(30 ILCS 105/5.1038 new)

Sec. 5.1038. The Safety-Net Hospital Access Fund.

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