

HB4741



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB4741

Introduced 2/6/2024, by Rep. Kam Buckner

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5A-12.7

Amends the Hospital Provider Funding Article of the Illinois Public Aid Code. In a provision requiring the Department of Healthcare and Family Services to create a pool of funding of at least \$50,000,000 annually to be disbursed among safety-net hospitals that maintain perinatal designation from the Department of Public Health, provides that no safety-net hospital eligible for funds shall receive less than \$5,000,000 annually.

LRB103 37771 KTG 67900 b

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5A-12.7 as follows:

6 (305 ILCS 5/5A-12.7)

7 (Section scheduled to be repealed on December 31, 2026)

8 Sec. 5A-12.7. Continuation of hospital access payments on
9 and after July 1, 2020.

10 (a) To preserve and improve access to hospital services,
11 for hospital services rendered on and after July 1, 2020, the
12 Department shall, except for hospitals described in subsection
13 (b) of Section 5A-3, make payments to hospitals or require
14 capitated managed care organizations to make payments as set
15 forth in this Section. Payments under this Section are not due
16 and payable, however, until: (i) the methodologies described
17 in this Section are approved by the federal government in an
18 appropriate State Plan amendment or directed payment preprint;
19 and (ii) the assessment imposed under this Article is
20 determined to be a permissible tax under Title XIX of the
21 Social Security Act. In determining the hospital access
22 payments authorized under subsection (g) of this Section, if a
23 hospital ceases to qualify for payments from the pool, the

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

6 (b) Amounts moved into claims-based rates and distributed
7 in accordance with Section 14-12 shall remain in those
8 claims-based rates.

9 (c) Graduate medical education.

10 (1) The calculation of graduate medical education
11 payments shall be based on the hospital's Medicare cost
12 report ending in Calendar Year 2018, as reported in the
13 Healthcare Cost Report Information System file, release
14 date September 30, 2019. An Illinois hospital reporting
15 intern and resident cost on its Medicare cost report shall
16 be eligible for graduate medical education payments.

17 (2) Each hospital's annualized Medicaid Intern
18 Resident Cost is calculated using annualized intern and
19 resident total costs obtained from Worksheet B Part I,
20 Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93,
21 96-98, and 105-112 multiplied by the percentage that the
22 hospital's Medicaid days (Worksheet S3 Part I, Column 7,
23 Lines 2, 3, 4, 14, 16-18, and 32) comprise of the
24 hospital's total days (Worksheet S3 Part I, Column 8,
25 Lines 14, 16-18, and 32).

26 (3) An annualized Medicaid indirect medical education

1 (IME) payment is calculated for each hospital using its
2 IME payments (Worksheet E Part A, Line 29, Column 1)
3 multiplied by the percentage that its Medicaid days
4 (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18,
5 and 32) comprise of its Medicare days (Worksheet S3 Part
6 I, Column 6, Lines 2, 3, 4, 14, and 16-18).

7 (4) For each hospital, its annualized Medicaid Intern
8 Resident Cost and its annualized Medicaid IME payment are
9 summed, and, except as capped at 120% of the average cost
10 per intern and resident for all qualifying hospitals as
11 calculated under this paragraph, is multiplied by the
12 applicable reimbursement factor as described in this
13 paragraph, to determine the hospital's final graduate
14 medical education payment. Each hospital's average cost
15 per intern and resident shall be calculated by summing its
16 total annualized Medicaid Intern Resident Cost plus its
17 annualized Medicaid IME payment and dividing that amount
18 by the hospital's total Full Time Equivalent Residents and
19 Interns. If the hospital's average per intern and resident
20 cost is greater than 120% of the same calculation for all
21 qualifying hospitals, the hospital's per intern and
22 resident cost shall be capped at 120% of the average cost
23 for all qualifying hospitals.

24 (A) For the period of July 1, 2020 through
25 December 31, 2022, the applicable reimbursement factor
26 shall be 22.6%.

1 (B) For the period of January 1, 2023 through
2 December 31, 2026, the applicable reimbursement factor
3 shall be 35% for all qualified safety-net hospitals,
4 as defined in Section 5-5e.1 of this Code, and all
5 hospitals with 100 or more Full Time Equivalent
6 Residents and Interns, as reported on the hospital's
7 Medicare cost report ending in Calendar Year 2018, and
8 for all other qualified hospitals the applicable
9 reimbursement factor shall be 30%.

10 (d) Fee-for-service supplemental payments. For the period
11 of July 1, 2020 through December 31, 2022, each Illinois
12 hospital shall receive an annual payment equal to the amounts
13 below, to be paid in 12 equal installments on or before the
14 seventh State business day of each month, except that no
15 payment shall be due within 30 days after the later of the date
16 of notification of federal approval of the payment
17 methodologies required under this Section or any waiver
18 required under 42 CFR 433.68, at which time the sum of amounts
19 required under this Section prior to the date of notification
20 is due and payable.

21 (1) For critical access hospitals, \$385 per covered
22 inpatient day contained in paid fee-for-service claims and
23 \$530 per paid fee-for-service outpatient claim for dates
24 of service in Calendar Year 2019 in the Department's
25 Enterprise Data Warehouse as of May 11, 2020.

26 (2) For safety-net hospitals, \$960 per covered

1 inpatient day contained in paid fee-for-service claims and
2 \$625 per paid fee-for-service outpatient claim for dates
3 of service in Calendar Year 2019 in the Department's
4 Enterprise Data Warehouse as of May 11, 2020.

5 (3) For long term acute care hospitals, \$295 per
6 covered inpatient day contained in paid fee-for-service
7 claims for dates of service in Calendar Year 2019 in the
8 Department's Enterprise Data Warehouse as of May 11, 2020.

9 (4) For freestanding psychiatric hospitals, \$125 per
10 covered inpatient day contained in paid fee-for-service
11 claims and \$130 per paid fee-for-service outpatient claim
12 for dates of service in Calendar Year 2019 in the
13 Department's Enterprise Data Warehouse as of May 11, 2020.

14 (5) For freestanding rehabilitation hospitals, \$355
15 per covered inpatient day contained in paid
16 fee-for-service claims for dates of service in Calendar
17 Year 2019 in the Department's Enterprise Data Warehouse as
18 of May 11, 2020.

19 (6) For all general acute care hospitals and high
20 Medicaid hospitals as defined in subsection (f), \$350 per
21 covered inpatient day for dates of service in Calendar
22 Year 2019 contained in paid fee-for-service claims and
23 \$620 per paid fee-for-service outpatient claim in the
24 Department's Enterprise Data Warehouse as of May 11, 2020.

25 (7) Alzheimer's treatment access payment. Each
26 Illinois academic medical center or teaching hospital, as

1 defined in Section 5-5e.2 of this Code, that is identified
2 as the primary hospital affiliate of one of the Regional
3 Alzheimer's Disease Assistance Centers, as designated by
4 the Alzheimer's Disease Assistance Act and identified in
5 the Department of Public Health's Alzheimer's Disease
6 State Plan dated December 2016, shall be paid an
7 Alzheimer's treatment access payment equal to the product
8 of the qualifying hospital's State Fiscal Year 2018 total
9 inpatient fee-for-service days multiplied by the
10 applicable Alzheimer's treatment rate of \$226.30 for
11 hospitals located in Cook County and \$116.21 for hospitals
12 located outside Cook County.

13 (d-2) Fee-for-service supplemental payments. Beginning
14 January 1, 2023, each Illinois hospital shall receive an
15 annual payment equal to the amounts listed below, to be paid in
16 12 equal installments on or before the seventh State business
17 day of each month, except that no payment shall be due within
18 30 days after the later of the date of notification of federal
19 approval of the payment methodologies required under this
20 Section or any waiver required under 42 CFR 433.68, at which
21 time the sum of amounts required under this Section prior to
22 the date of notification is due and payable. The Department
23 may adjust the rates in paragraphs (1) through (7) to comply
24 with the federal upper payment limits, with such adjustments
25 being determined so that the total estimated spending by
26 hospital class, under such adjusted rates, remains

1 substantially similar to the total estimated spending under
2 the original rates set forth in this subsection.

3 (1) For critical access hospitals, as defined in
4 subsection (f), \$750 per covered inpatient day contained
5 in paid fee-for-service claims and \$750 per paid
6 fee-for-service outpatient claim for dates of service in
7 Calendar Year 2019 in the Department's Enterprise Data
8 Warehouse as of August 6, 2021.

9 (2) For safety-net hospitals, as described in
10 subsection (f), \$1,350 per inpatient day contained in paid
11 fee-for-service claims and \$1,350 per paid fee-for-service
12 outpatient claim for dates of service in Calendar Year
13 2019 in the Department's Enterprise Data Warehouse as of
14 August 6, 2021.

15 (3) For long term acute care hospitals, \$550 per
16 covered inpatient day contained in paid fee-for-service
17 claims for dates of service in Calendar Year 2019 in the
18 Department's Enterprise Data Warehouse as of August 6,
19 2021.

20 (4) For freestanding psychiatric hospitals, \$200 per
21 covered inpatient day contained in paid fee-for-service
22 claims and \$200 per paid fee-for-service outpatient claim
23 for dates of service in Calendar Year 2019 in the
24 Department's Enterprise Data Warehouse as of August 6,
25 2021.

26 (5) For freestanding rehabilitation hospitals, \$550

1 per covered inpatient day contained in paid
2 fee-for-service claims and \$125 per paid fee-for-service
3 outpatient claim for dates of service in Calendar Year
4 2019 in the Department's Enterprise Data Warehouse as of
5 August 6, 2021.

6 (6) For all general acute care hospitals and high
7 Medicaid hospitals as defined in subsection (f), \$500 per
8 covered inpatient day for dates of service in Calendar
9 Year 2019 contained in paid fee-for-service claims and
10 \$500 per paid fee-for-service outpatient claim in the
11 Department's Enterprise Data Warehouse as of August 6,
12 2021.

13 (7) For public hospitals, as defined in subsection
14 (f), \$275 per covered inpatient day contained in paid
15 fee-for-service claims and \$275 per paid fee-for-service
16 outpatient claim for dates of service in Calendar Year
17 2019 in the Department's Enterprise Data Warehouse as of
18 August 6, 2021.

19 (8) Alzheimer's treatment access payment. Each
20 Illinois academic medical center or teaching hospital, as
21 defined in Section 5-5e.2 of this Code, that is identified
22 as the primary hospital affiliate of one of the Regional
23 Alzheimer's Disease Assistance Centers, as designated by
24 the Alzheimer's Disease Assistance Act and identified in
25 the Department of Public Health's Alzheimer's Disease
26 State Plan dated December 2016, shall be paid an

1 Alzheimer's treatment access payment equal to the product
2 of the qualifying hospital's Calendar Year 2019 total
3 inpatient fee-for-service days, in the Department's
4 Enterprise Data Warehouse as of August 6, 2021, multiplied
5 by the applicable Alzheimer's treatment rate of \$244.37
6 for hospitals located in Cook County and \$312.03 for
7 hospitals located outside Cook County.

8 (e) The Department shall require managed care
9 organizations (MCOs) to make directed payments and
10 pass-through payments according to this Section. Each calendar
11 year, the Department shall require MCOs to pay the maximum
12 amount out of these funds as allowed as pass-through payments
13 under federal regulations. The Department shall require MCOs
14 to make such pass-through payments as specified in this
15 Section. The Department shall require the MCOs to pay the
16 remaining amounts as directed Payments as specified in this
17 Section. The Department shall issue payments to the
18 Comptroller by the seventh business day of each month for all
19 MCOs that are sufficient for MCOs to make the directed
20 payments and pass-through payments according to this Section.
21 The Department shall require the MCOs to make pass-through
22 payments and directed payments using electronic funds
23 transfers (EFT), if the hospital provides the information
24 necessary to process such EFTs, in accordance with directions
25 provided monthly by the Department, within 7 business days of
26 the date the funds are paid to the MCOs, as indicated by the

1 "Paid Date" on the website of the Office of the Comptroller if
2 the funds are paid by EFT and the MCOs have received directed
3 payment instructions. If funds are not paid through the
4 Comptroller by EFT, payment must be made within 7 business
5 days of the date actually received by the MCO. The MCO will be
6 considered to have paid the pass-through payments when the
7 payment remittance number is generated or the date the MCO
8 sends the check to the hospital, if EFT information is not
9 supplied. If an MCO is late in paying a pass-through payment or
10 directed payment as required under this Section (including any
11 extensions granted by the Department), it shall pay a penalty,
12 unless waived by the Department for reasonable cause, to the
13 Department equal to 5% of the amount of the pass-through
14 payment or directed payment not paid on or before the due date
15 plus 5% of the portion thereof remaining unpaid on the last day
16 of each 30-day period thereafter. Payments to MCOs that would
17 be paid consistent with actuarial certification and enrollment
18 in the absence of the increased capitation payments under this
19 Section shall not be reduced as a consequence of payments made
20 under this subsection. The Department shall publish and
21 maintain on its website for a period of no less than 8 calendar
22 quarters, the quarterly calculation of directed payments and
23 pass-through payments owed to each hospital from each MCO. All
24 calculations and reports shall be posted no later than the
25 first day of the quarter for which the payments are to be
26 issued.

1 (f) (1) For purposes of allocating the funds included in
2 capitation payments to MCOs, Illinois hospitals shall be
3 divided into the following classes as defined in
4 administrative rules:

5 (A) Beginning July 1, 2020 through December 31, 2022,
6 critical access hospitals. Beginning January 1, 2023,
7 "critical access hospital" means a hospital designated by
8 the Department of Public Health as a critical access
9 hospital, excluding any hospital meeting the definition of
10 a public hospital in subparagraph (F).

11 (B) Safety-net hospitals, except that stand-alone
12 children's hospitals that are not specialty children's
13 hospitals will not be included. For the calendar year
14 beginning January 1, 2023, and each calendar year
15 thereafter, assignment to the safety-net class shall be
16 based on the annual safety-net rate year beginning 15
17 months before the beginning of the first Payout Quarter of
18 the calendar year.

19 (C) Long term acute care hospitals.

20 (D) Freestanding psychiatric hospitals.

21 (E) Freestanding rehabilitation hospitals.

22 (F) Beginning January 1, 2023, "public hospital" means
23 a hospital that is owned or operated by an Illinois
24 Government body or municipality, excluding a hospital
25 provider that is a State agency, a State university, or a
26 county with a population of 3,000,000 or more.

1 (G) High Medicaid hospitals.

2 (i) As used in this Section, "high Medicaid
3 hospital" means a general acute care hospital that:

4 (I) For the payout periods July 1, 2020
5 through December 31, 2022, is not a safety-net
6 hospital or critical access hospital and that has
7 a Medicaid Inpatient Utilization Rate above 30% or
8 a hospital that had over 35,000 inpatient Medicaid
9 days during the applicable period. For the period
10 July 1, 2020 through December 31, 2020, the
11 applicable period for the Medicaid Inpatient
12 Utilization Rate (MIUR) is the rate year 2020 MIUR
13 and for the number of inpatient days it is State
14 fiscal year 2018. Beginning in calendar year 2021,
15 the Department shall use the most recently
16 determined MIUR, as defined in subsection (h) of
17 Section 5-5.02, and for the inpatient day
18 threshold, the State fiscal year ending 18 months
19 prior to the beginning of the calendar year. For
20 purposes of calculating MIUR under this Section,
21 children's hospitals and affiliated general acute
22 care hospitals shall be considered a single
23 hospital.

24 (II) For the calendar year beginning January
25 1, 2023, and each calendar year thereafter, is not
26 a public hospital, safety-net hospital, or

1 critical access hospital and that qualifies as a
2 regional high volume hospital or is a hospital
3 that has a Medicaid Inpatient Utilization Rate
4 (MIUR) above 30%. As used in this item, "regional
5 high volume hospital" means a hospital which ranks
6 in the top 2 quartiles based on total hospital
7 services volume, of all eligible general acute
8 care hospitals, when ranked in descending order
9 based on total hospital services volume, within
10 the same Medicaid managed care region, as
11 designated by the Department, as of January 1,
12 2022. As used in this item, "total hospital
13 services volume" means the total of all Medical
14 Assistance hospital inpatient admissions plus all
15 Medical Assistance hospital outpatient visits. For
16 purposes of determining regional high volume
17 hospital inpatient admissions and outpatient
18 visits, the Department shall use dates of service
19 provided during State Fiscal Year 2020 for the
20 Payout Quarter beginning January 1, 2023. The
21 Department shall use dates of service from the
22 State fiscal year ending 18 month before the
23 beginning of the first Payout Quarter of the
24 subsequent annual determination period.

25 (ii) For the calendar year beginning January 1,
26 2023, the Department shall use the Rate Year 2022

1 Medicaid inpatient utilization rate (MIUR), as defined
2 in subsection (h) of Section 5-5.02. For each
3 subsequent annual determination, the Department shall
4 use the MIUR applicable to the rate year ending
5 September 30 of the year preceding the beginning of
6 the calendar year.

7 (H) General acute care hospitals. As used under this
8 Section, "general acute care hospitals" means all other
9 Illinois hospitals not identified in subparagraphs (A)
10 through (G).

11 (2) Hospitals' qualification for each class shall be
12 assessed prior to the beginning of each calendar year and the
13 new class designation shall be effective January 1 of the next
14 year. The Department shall publish by rule the process for
15 establishing class determination.

16 (3) Beginning January 1, 2024, the Department may reassign
17 hospitals or entire hospital classes as defined above, if
18 federal limits on the payments to the class to which the
19 hospitals are assigned based on the criteria in this
20 subsection prevent the Department from making payments to the
21 class that would otherwise be due under this Section. The
22 Department shall publish the criteria and composition of each
23 new class based on the reassignments, and the projected impact
24 on payments to each hospital under the new classes on its
25 website by November 15 of the year before the year in which the
26 class changes become effective.

1 (g) Fixed pool directed payments. Beginning July 1, 2020,
2 the Department shall issue payments to MCOs which shall be
3 used to issue directed payments to qualified Illinois
4 safety-net hospitals and critical access hospitals on a
5 monthly basis in accordance with this subsection. Prior to the
6 beginning of each Payout Quarter beginning July 1, 2020, the
7 Department shall use encounter claims data from the
8 Determination Quarter, accepted by the Department's Medicaid
9 Management Information System for inpatient and outpatient
10 services rendered by safety-net hospitals and critical access
11 hospitals to determine a quarterly uniform per unit add-on for
12 each hospital class.

13 (1) Inpatient per unit add-on. A quarterly uniform per
14 diem add-on shall be derived by dividing the quarterly
15 Inpatient Directed Payments Pool amount allocated to the
16 applicable hospital class by the total inpatient days
17 contained on all encounter claims received during the
18 Determination Quarter, for all hospitals in the class.

19 (A) Each hospital in the class shall have a
20 quarterly inpatient directed payment calculated that
21 is equal to the product of the number of inpatient days
22 attributable to the hospital used in the calculation
23 of the quarterly uniform class per diem add-on,
24 multiplied by the calculated applicable quarterly
25 uniform class per diem add-on of the hospital class.

26 (B) Each hospital shall be paid 1/3 of its

1 quarterly inpatient directed payment in each of the 3
2 months of the Payout Quarter, in accordance with
3 directions provided to each MCO by the Department.

4 (2) Outpatient per unit add-on. A quarterly uniform
5 per claim add-on shall be derived by dividing the
6 quarterly Outpatient Directed Payments Pool amount
7 allocated to the applicable hospital class by the total
8 outpatient encounter claims received during the
9 Determination Quarter, for all hospitals in the class.

10 (A) Each hospital in the class shall have a
11 quarterly outpatient directed payment calculated that
12 is equal to the product of the number of outpatient
13 encounter claims attributable to the hospital used in
14 the calculation of the quarterly uniform class per
15 claim add-on, multiplied by the calculated applicable
16 quarterly uniform class per claim add-on of the
17 hospital class.

18 (B) Each hospital shall be paid 1/3 of its
19 quarterly outpatient directed payment in each of the 3
20 months of the Payout Quarter, in accordance with
21 directions provided to each MCO by the Department.

22 (3) Each MCO shall pay each hospital the Monthly
23 Directed Payment as identified by the Department on its
24 quarterly determination report.

25 (4) Definitions. As used in this subsection:

26 (A) "Payout Quarter" means each 3 month calendar

1 quarter, beginning July 1, 2020.

2 (B) "Determination Quarter" means each 3 month
3 calendar quarter, which ends 3 months prior to the
4 first day of each Payout Quarter.

5 (5) For the period July 1, 2020 through December 2020,
6 the following amounts shall be allocated to the following
7 hospital class directed payment pools for the quarterly
8 development of a uniform per unit add-on:

9 (A) \$2,894,500 for hospital inpatient services for
10 critical access hospitals.

11 (B) \$4,294,374 for hospital outpatient services
12 for critical access hospitals.

13 (C) \$29,109,330 for hospital inpatient services
14 for safety-net hospitals.

15 (D) \$35,041,218 for hospital outpatient services
16 for safety-net hospitals.

17 (6) For the period January 1, 2023 through December
18 31, 2023, the Department shall establish the amounts that
19 shall be allocated to the hospital class directed payment
20 fixed pools identified in this paragraph for the quarterly
21 development of a uniform per unit add-on. The Department
22 shall establish such amounts so that the total amount of
23 payments to each hospital under this Section in calendar
24 year 2023 is projected to be substantially similar to the
25 total amount of such payments received by the hospital
26 under this Section in calendar year 2021, adjusted for

1 increased funding provided for fixed pool directed
2 payments under subsection (g) in calendar year 2022,
3 assuming that the volume and acuity of claims are held
4 constant. The Department shall publish the directed
5 payment fixed pool amounts to be established under this
6 paragraph on its website by November 15, 2022.

7 (A) Hospital inpatient services for critical
8 access hospitals.

9 (B) Hospital outpatient services for critical
10 access hospitals.

11 (C) Hospital inpatient services for public
12 hospitals.

13 (D) Hospital outpatient services for public
14 hospitals.

15 (E) Hospital inpatient services for safety-net
16 hospitals.

17 (F) Hospital outpatient services for safety-net
18 hospitals.

19 (7) Semi-annual rate maintenance review. The
20 Department shall ensure that hospitals assigned to the
21 fixed pools in paragraph (6) are paid no less than 95% of
22 the annual initial rate for each 6-month period of each
23 annual payout period. For each calendar year, the
24 Department shall calculate the annual initial rate per day
25 and per visit for each fixed pool hospital class listed in
26 paragraph (6), by dividing the total of all applicable

1 inpatient or outpatient directed payments issued in the
2 preceding calendar year to the hospitals in each fixed
3 pool class for the calendar year, plus any increase
4 resulting from the annual adjustments described in
5 subsection (i), by the actual applicable total service
6 units for the preceding calendar year which were the basis
7 of the total applicable inpatient or outpatient directed
8 payments issued to the hospitals in each fixed pool class
9 in the calendar year, except that for calendar year 2023,
10 the service units from calendar year 2021 shall be used.

11 (A) The Department shall calculate the effective
12 rate, per day and per visit, for the payout periods of
13 January to June and July to December of each year, for
14 each fixed pool listed in paragraph (6), by dividing
15 50% of the annual pool by the total applicable
16 reported service units for the 2 applicable
17 determination quarters.

18 (B) If the effective rate calculated in
19 subparagraph (A) is less than 95% of the annual
20 initial rate assigned to the class for each pool under
21 paragraph (6), the Department shall adjust the payment
22 for each hospital to a level equal to no less than 95%
23 of the annual initial rate, by issuing a retroactive
24 adjustment payment for the 6-month period under review
25 as identified in subparagraph (A).

26 (h) Fixed rate directed payments. Effective July 1, 2020,

1 the Department shall issue payments to MCOs which shall be
2 used to issue directed payments to Illinois hospitals not
3 identified in paragraph (g) on a monthly basis. Prior to the
4 beginning of each Payout Quarter beginning July 1, 2020, the
5 Department shall use encounter claims data from the
6 Determination Quarter, accepted by the Department's Medicaid
7 Management Information System for inpatient and outpatient
8 services rendered by hospitals in each hospital class
9 identified in paragraph (f) and not identified in paragraph
10 (g). For the period July 1, 2020 through December 2020, the
11 Department shall direct MCOs to make payments as follows:

12 (1) For general acute care hospitals an amount equal
13 to \$1,750 multiplied by the hospital's category of service
14 20 case mix index for the determination quarter multiplied
15 by the hospital's total number of inpatient admissions for
16 category of service 20 for the determination quarter.

17 (2) For general acute care hospitals an amount equal
18 to \$160 multiplied by the hospital's category of service
19 21 case mix index for the determination quarter multiplied
20 by the hospital's total number of inpatient admissions for
21 category of service 21 for the determination quarter.

22 (3) For general acute care hospitals an amount equal
23 to \$80 multiplied by the hospital's category of service 22
24 case mix index for the determination quarter multiplied by
25 the hospital's total number of inpatient admissions for
26 category of service 22 for the determination quarter.

1 (4) For general acute care hospitals an amount equal
2 to \$375 multiplied by the hospital's category of service
3 24 case mix index for the determination quarter multiplied
4 by the hospital's total number of category of service 24
5 paid EAPG (EAPGs) for the determination quarter.

6 (5) For general acute care hospitals an amount equal
7 to \$240 multiplied by the hospital's category of service
8 27 and 28 case mix index for the determination quarter
9 multiplied by the hospital's total number of category of
10 service 27 and 28 paid EAPGs for the determination
11 quarter.

12 (6) For general acute care hospitals an amount equal
13 to \$290 multiplied by the hospital's category of service
14 29 case mix index for the determination quarter multiplied
15 by the hospital's total number of category of service 29
16 paid EAPGs for the determination quarter.

17 (7) For high Medicaid hospitals an amount equal to
18 \$1,800 multiplied by the hospital's category of service 20
19 case mix index for the determination quarter multiplied by
20 the hospital's total number of inpatient admissions for
21 category of service 20 for the determination quarter.

22 (8) For high Medicaid hospitals an amount equal to
23 \$160 multiplied by the hospital's category of service 21
24 case mix index for the determination quarter multiplied by
25 the hospital's total number of inpatient admissions for
26 category of service 21 for the determination quarter.

1 (9) For high Medicaid hospitals an amount equal to \$80
2 multiplied by the hospital's category of service 22 case
3 mix index for the determination quarter multiplied by the
4 hospital's total number of inpatient admissions for
5 category of service 22 for the determination quarter.

6 (10) For high Medicaid hospitals an amount equal to
7 \$400 multiplied by the hospital's category of service 24
8 case mix index for the determination quarter multiplied by
9 the hospital's total number of category of service 24 paid
10 EAPG outpatient claims for the determination quarter.

11 (11) For high Medicaid hospitals an amount equal to
12 \$240 multiplied by the hospital's category of service 27
13 and 28 case mix index for the determination quarter
14 multiplied by the hospital's total number of category of
15 service 27 and 28 paid EAPGs for the determination
16 quarter.

17 (12) For high Medicaid hospitals an amount equal to
18 \$290 multiplied by the hospital's category of service 29
19 case mix index for the determination quarter multiplied by
20 the hospital's total number of category of service 29 paid
21 EAPGs for the determination quarter.

22 (13) For long term acute care hospitals the amount of
23 \$495 multiplied by the hospital's total number of
24 inpatient days for the determination quarter.

25 (14) For psychiatric hospitals the amount of \$210
26 multiplied by the hospital's total number of inpatient

1 days for category of service 21 for the determination
2 quarter.

3 (15) For psychiatric hospitals the amount of \$250
4 multiplied by the hospital's total number of outpatient
5 claims for category of service 27 and 28 for the
6 determination quarter.

7 (16) For rehabilitation hospitals the amount of \$410
8 multiplied by the hospital's total number of inpatient
9 days for category of service 22 for the determination
10 quarter.

11 (17) For rehabilitation hospitals the amount of \$100
12 multiplied by the hospital's total number of outpatient
13 claims for category of service 29 for the determination
14 quarter.

15 (18) Effective for the Payout Quarter beginning
16 January 1, 2023, for the directed payments to hospitals
17 required under this subsection, the Department shall
18 establish the amounts that shall be used to calculate such
19 directed payments using the methodologies specified in
20 this paragraph. The Department shall use a single, uniform
21 rate, adjusted for acuity as specified in paragraphs (1)
22 through (12), for all categories of inpatient services
23 provided by each class of hospitals and a single uniform
24 rate, adjusted for acuity as specified in paragraphs (1)
25 through (12), for all categories of outpatient services
26 provided by each class of hospitals. The Department shall

1 establish such amounts so that the total amount of
2 payments to each hospital under this Section in calendar
3 year 2023 is projected to be substantially similar to the
4 total amount of such payments received by the hospital
5 under this Section in calendar year 2021, adjusted for
6 increased funding provided for fixed pool directed
7 payments under subsection (g) in calendar year 2022,
8 assuming that the volume and acuity of claims are held
9 constant. The Department shall publish the directed
10 payment amounts to be established under this subsection on
11 its website by November 15, 2022.

12 (19) Each hospital shall be paid 1/3 of their
13 quarterly inpatient and outpatient directed payment in
14 each of the 3 months of the Payout Quarter, in accordance
15 with directions provided to each MCO by the Department.

16 (20) Each MCO shall pay each hospital the Monthly
17 Directed Payment amount as identified by the Department on
18 its quarterly determination report.

19 Notwithstanding any other provision of this subsection, if
20 the Department determines that the actual total hospital
21 utilization data that is used to calculate the fixed rate
22 directed payments is substantially different than anticipated
23 when the rates in this subsection were initially determined
24 for unforeseeable circumstances (such as the COVID-19 pandemic
25 or some other public health emergency), the Department may
26 adjust the rates specified in this subsection so that the

1 total directed payments approximate the total spending amount
2 anticipated when the rates were initially established.

3 Definitions. As used in this subsection:

4 (A) "Payout Quarter" means each calendar quarter,
5 beginning July 1, 2020.

6 (B) "Determination Quarter" means each calendar
7 quarter which ends 3 months prior to the first day of
8 each Payout Quarter.

9 (C) "Case mix index" means a hospital specific
10 calculation. For inpatient claims the case mix index
11 is calculated each quarter by summing the relative
12 weight of all inpatient Diagnosis-Related Group (DRG)
13 claims for a category of service in the applicable
14 Determination Quarter and dividing the sum by the
15 number of sum total of all inpatient DRG admissions
16 for the category of service for the associated claims.
17 The case mix index for outpatient claims is calculated
18 each quarter by summing the relative weight of all
19 paid EAPGs in the applicable Determination Quarter and
20 dividing the sum by the sum total of paid EAPGs for the
21 associated claims.

22 (i) Beginning January 1, 2021, the rates for directed
23 payments shall be recalculated in order to spend the
24 additional funds for directed payments that result from
25 reduction in the amount of pass-through payments allowed under
26 federal regulations. The additional funds for directed

1 payments shall be allocated proportionally to each class of
2 hospitals based on that class' proportion of services.

3 (1) Beginning January 1, 2024, the fixed pool directed
4 payment amounts and the associated annual initial rates
5 referenced in paragraph (6) of subsection (f) for each
6 hospital class shall be uniformly increased by a ratio of
7 not less than, the ratio of the total pass-through
8 reduction amount pursuant to paragraph (4) of subsection
9 (j), for the hospitals comprising the hospital fixed pool
10 directed payment class for the next calendar year, to the
11 total inpatient and outpatient directed payments for the
12 hospitals comprising the hospital fixed pool directed
13 payment class paid during the preceding calendar year.

14 (2) Beginning January 1, 2024, the fixed rates for the
15 directed payments referenced in paragraph (18) of
16 subsection (h) for each hospital class shall be uniformly
17 increased by a ratio of not less than, the ratio of the
18 total pass-through reduction amount pursuant to paragraph
19 (4) of subsection (j), for the hospitals comprising the
20 hospital directed payment class for the next calendar
21 year, to the total inpatient and outpatient directed
22 payments for the hospitals comprising the hospital fixed
23 rate directed payment class paid during the preceding
24 calendar year.

25 (j) Pass-through payments.

26 (1) For the period July 1, 2020 through December 31,

1 2020, the Department shall assign quarterly pass-through
2 payments to each class of hospitals equal to one-fourth of
3 the following annual allocations:

4 (A) \$390,487,095 to safety-net hospitals.

5 (B) \$62,553,886 to critical access hospitals.

6 (C) \$345,021,438 to high Medicaid hospitals.

7 (D) \$551,429,071 to general acute care hospitals.

8 (E) \$27,283,870 to long term acute care hospitals.

9 (F) \$40,825,444 to freestanding psychiatric
10 hospitals.

11 (G) \$9,652,108 to freestanding rehabilitation
12 hospitals.

13 (2) For the period of July 1, 2020 through December
14 31, 2020, the pass-through payments shall at a minimum
15 ensure hospitals receive a total amount of monthly
16 payments under this Section as received in calendar year
17 2019 in accordance with this Article and paragraph (1) of
18 subsection (d-5) of Section 14-12, exclusive of amounts
19 received through payments referenced in subsection (b).

20 (3) For the calendar year beginning January 1, 2023,
21 the Department shall establish the annual pass-through
22 allocation to each class of hospitals and the pass-through
23 payments to each hospital so that the total amount of
24 payments to each hospital under this Section in calendar
25 year 2023 is projected to be substantially similar to the
26 total amount of such payments received by the hospital

1 under this Section in calendar year 2021, adjusted for
2 increased funding provided for fixed pool directed
3 payments under subsection (g) in calendar year 2022,
4 assuming that the volume and acuity of claims are held
5 constant. The Department shall publish the pass-through
6 allocation to each class and the pass-through payments to
7 each hospital to be established under this subsection on
8 its website by November 15, 2022.

9 (4) For the calendar years beginning January 1, 2021
10 and January 1, 2022, each hospital's pass-through payment
11 amount shall be reduced proportionally to the reduction of
12 all pass-through payments required by federal regulations.
13 Beginning January 1, 2024, the Department shall reduce
14 total pass-through payments by the minimum amount
15 necessary to comply with federal regulations. Pass-through
16 payments to safety-net hospitals, as defined in Section
17 5-5e.1 of this Code, shall not be reduced until all
18 pass-through payments to other hospitals have been
19 eliminated. All other hospitals shall have their
20 pass-through payments reduced proportionally.

21 (k) At least 30 days prior to each calendar year, the
22 Department shall notify each hospital of changes to the
23 payment methodologies in this Section, including, but not
24 limited to, changes in the fixed rate directed payment rates,
25 the aggregate pass-through payment amount for all hospitals,
26 and the hospital's pass-through payment amount for the

1 upcoming calendar year.

2 (l) Notwithstanding any other provisions of this Section,
3 the Department may adopt rules to change the methodology for
4 directed and pass-through payments as set forth in this
5 Section, but only to the extent necessary to obtain federal
6 approval of a necessary State Plan amendment or Directed
7 Payment Preprint or to otherwise conform to federal law or
8 federal regulation.

9 (m) As used in this subsection, "managed care
10 organization" or "MCO" means an entity which contracts with
11 the Department to provide services where payment for medical
12 services is made on a capitated basis, excluding contracted
13 entities for dual eligible or Department of Children and
14 Family Services youth populations.

15 (n) In order to address the escalating infant mortality
16 rates among minority communities in Illinois, the State shall,
17 subject to appropriation, create a pool of funding of at least
18 \$50,000,000 annually to be disbursed among safety-net
19 hospitals that maintain perinatal designation from the
20 Department of Public Health. No safety-net hospital eligible
21 for funds under this subsection shall receive less than
22 \$5,000,000 annually. The funding shall be used to preserve or
23 enhance OB/GYN services or other specialty services at the
24 receiving hospital, with the distribution of funding to be
25 established by rule and with consideration to perinatal
26 hospitals with safe birthing levels and quality metrics for

1 healthy mothers and babies.

2 (o) In order to address the growing challenges of
3 providing stable access to healthcare in rural Illinois,
4 including perinatal services, behavioral healthcare including
5 substance use disorder services (SUDs) and other specialty
6 services, and to expand access to telehealth services among
7 rural communities in Illinois, the Department of Healthcare
8 and Family Services shall administer a program to provide at
9 least \$10,000,000 in financial support annually to critical
10 access hospitals for delivery of perinatal and OB/GYN
11 services, behavioral healthcare including SUDs, other
12 specialty services and telehealth services. The funding shall
13 be used to preserve or enhance perinatal and OB/GYN services,
14 behavioral healthcare including SUDs, other specialty
15 services, as well as the explanation of telehealth services by
16 the receiving hospital, with the distribution of funding to be
17 established by rule.

18 (p) For calendar year 2023, the final amounts, rates, and
19 payments under subsections (c), (d-2), (g), (h), and (j) shall
20 be established by the Department, so that the sum of the total
21 estimated annual payments under subsections (c), (d-2), (g),
22 (h), and (j) for each hospital class for calendar year 2023, is
23 no less than:

24 (1) \$858,260,000 to safety-net hospitals.

25 (2) \$86,200,000 to critical access hospitals.

26 (3) \$1,765,000,000 to high Medicaid hospitals.

- 1 (4) \$673,860,000 to general acute care hospitals.
- 2 (5) \$48,330,000 to long term acute care hospitals.
- 3 (6) \$89,110,000 to freestanding psychiatric hospitals.
- 4 (7) \$24,300,000 to freestanding rehabilitation
5 hospitals.
- 6 (8) \$32,570,000 to public hospitals.
- 7 (q) Hospital Pandemic Recovery Stabilization Payments. The
8 Department shall disburse a pool of \$460,000,000 in stability
9 payments to hospitals prior to April 1, 2023. The allocation
10 of the pool shall be based on the hospital directed payment
11 classes and directed payments issued, during Calendar Year
12 2022 with added consideration to safety net hospitals, as
13 defined in subdivision (f) (1) (B) of this Section, and critical
14 access hospitals.
- 15 (Source: P.A. 102-4, eff. 4-27-21; 102-16, eff. 6-17-21;
16 102-886, eff. 5-17-22; 102-1115, eff. 1-9-23; 103-102, eff.
17 6-16-23; revised 9-21-23.)