



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

HB1868

Introduced 1/29/2025, 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.

LRB104 09496 KTG 19557 b

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7 (Section scheduled to be repealed on December 31, 2026)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 and, for calendar years 2025 and 2026 only,  
14 hospitals with over 9,000 Medicaid acute care inpatient  
15 admissions per calendar year, excluding admissions for  
16 Medicare-Medicaid dual eligible patients, will not be  
17 included. For the calendar year beginning January 1, 2023,  
18 and each calendar year thereafter, assignment to the  
19 safety-net class shall be based on the annual safety-net  
20 rate year beginning 15 months before the beginning of the  
21 first Payout Quarter of the calendar year.

22 (C) Long term acute care hospitals.

23 (D) Freestanding psychiatric hospitals.

24 (E) Freestanding rehabilitation hospitals.

25 (F) Beginning January 1, 2023, "public hospital" means  
26 a hospital that is owned or operated by an Illinois

1 Government body or municipality, excluding a hospital  
2 provider that is a State agency, a State university, or a  
3 county with a population of 3,000,000 or more.

4 (G) High Medicaid hospitals.

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

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

(II) For the calendar year beginning January 1, 2023, and each calendar year thereafter, is not a public hospital, safety-net hospital, or critical access hospital and that qualifies as a regional high volume hospital or is a hospital that has a Medicaid Inpatient Utilization Rate (MIUR) above 30%. As used in this item, "regional high volume hospital" means a hospital which ranks in the top 2 quartiles based on total hospital services volume, of all eligible general acute care hospitals, when ranked in descending order based on total hospital services volume, within the same Medicaid managed care region, as designated by the Department, as of January 1, 2022. As used in this item, "total hospital services volume" means the total of all Medical Assistance hospital inpatient admissions plus all Medical Assistance hospital outpatient visits. For purposes of determining regional high volume hospital inpatient admissions and outpatient visits, the Department shall use dates of service provided during State Fiscal Year 2020 for the Payout Quarter beginning January 1, 2023. The Department shall use dates of service from the State fiscal year ending 18 month before the beginning of the first Payout Quarter of the

1 subsequent annual determination period.

2 (ii) For the calendar year beginning January 1,  
3 2023, the Department shall use the Rate Year 2022  
4 Medicaid inpatient utilization rate (MIUR), as defined  
5 in subsection (h) of Section 5-5.02. For each  
6 subsequent annual determination, the Department shall  
7 use the MIUR applicable to the rate year ending  
8 September 30 of the year preceding the beginning of  
9 the calendar year.

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

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

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

1 on payments to each hospital under the new classes on its  
2 website by November 15 of the year before the year in which the  
3 class changes become effective.

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

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

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



1 multiplied by the calculated applicable quarterly  
2 uniform class per diem add-on of the hospital class.

3 (B) Each hospital shall be paid 1/3 of its  
4 quarterly inpatient directed payment in each of the 3  
5 months of the Payout Quarter, in accordance with  
6 directions provided to each MCO by the Department.

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

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

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

25 (3) Each MCO shall pay each hospital the Monthly  
26 Directed Payment as identified by the Department on its

1       quarterly determination report.

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

3               (A) "Payout Quarter" means each 3 month calendar  
4       quarter, beginning July 1, 2020.

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

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

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

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

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

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

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

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

10 (A) Hospital inpatient services for critical  
11 access hospitals.

12 (B) Hospital outpatient services for critical  
13 access hospitals.

14 (C) Hospital inpatient services for public  
15 hospitals.

16 (D) Hospital outpatient services for public  
17 hospitals.

18 (E) Hospital inpatient services for safety-net  
19 hospitals.

20 (F) Hospital outpatient services for safety-net  
21 hospitals.

22 (7) Semi-annual rate maintenance review. The  
23 Department shall ensure that hospitals assigned to the  
24 fixed pools in paragraph (6) are paid no less than 95% of  
25 the annual initial rate for each 6-month period of each  
26 annual payout period. For each calendar year, the

1 Department shall calculate the annual initial rate per day  
2 and per visit for each fixed pool hospital class listed in  
3 paragraph (6), by dividing the total of all applicable  
4 inpatient or outpatient directed payments issued in the  
5 preceding calendar year to the hospitals in each fixed  
6 pool class for the calendar year, plus any increase  
7 resulting from the annual adjustments described in  
8 subsection (i), by the actual applicable total service  
9 units for the preceding calendar year which were the basis  
10 of the total applicable inpatient or outpatient directed  
11 payments issued to the hospitals in each fixed pool class  
12 in the calendar year, except that for calendar year 2023,  
13 the service units from calendar year 2021 shall be used.

14 (A) The Department shall calculate the effective  
15 rate, per day and per visit, for the payout periods of  
16 January to June and July to December of each year, for  
17 each fixed pool listed in paragraph (6), by dividing  
18 50% of the annual pool by the total applicable  
19 reported service units for the 2 applicable  
20 determination quarters.

21 (B) If the effective rate calculated in  
22 subparagraph (A) is less than 95% of the annual  
23 initial rate assigned to the class for each pool under  
24 paragraph (6), the Department shall adjust the payment  
25 for each hospital to a level equal to no less than 95%  
26 of the annual initial rate, by issuing a retroactive

1 adjustment payment for the 6-month period under review  
2 as identified in subparagraph (A).

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

15 (1) For general acute care hospitals an amount equal  
16 to \$1,750 multiplied by the hospital's category of service  
17 20 case mix index for the determination quarter multiplied  
18 by the hospital's total number of inpatient admissions for  
19 category of service 20 for the determination quarter.

20 (2) For general acute care hospitals an amount equal  
21 to \$160 multiplied by the hospital's category of service  
22 21 case mix index for the determination quarter multiplied  
23 by the hospital's total number of inpatient admissions for  
24 category of service 21 for the determination quarter.

25 (3) For general acute care hospitals an amount equal  
26 to \$80 multiplied by the hospital's category of service 22

1 case mix index for the determination quarter multiplied by  
2 the hospital's total number of inpatient admissions for  
3 category of service 22 for the determination quarter.

4 (4) For general acute care hospitals an amount equal  
5 to \$375 multiplied by the hospital's category of service  
6 24 case mix index for the determination quarter multiplied  
7 by the hospital's total number of category of service 24  
8 paid EAPG (EAPGs) for the determination quarter.

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

15 (6) For general acute care hospitals an amount equal  
16 to \$290 multiplied by the hospital's category of service  
17 29 case mix index for the determination quarter multiplied  
18 by the hospital's total number of category of service 29  
19 paid EAPGs for the determination quarter.

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

25 (8) For high Medicaid hospitals an amount equal to  
26 \$160 multiplied by the hospital's category of service 21

1 case mix index for the determination quarter multiplied by  
2 the hospital's total number of inpatient admissions for  
3 category of service 21 for the determination quarter.

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

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

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

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

25 (13) For long term acute care hospitals the amount of  
26 \$495 multiplied by the hospital's total number of

1 inpatient days for the determination quarter.

2 (14) For psychiatric hospitals the amount of \$210  
3 multiplied by the hospital's total number of inpatient  
4 days for category of service 21 for the determination  
5 quarter.

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

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

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

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



1 rate, adjusted for acuity as specified in paragraphs (1)  
2 through (12), for all categories of outpatient services  
3 provided by each class of hospitals. The Department shall  
4 establish such amounts so that the total amount of  
5 payments to each hospital under this Section in calendar  
6 year 2023 is projected to be substantially similar to the  
7 total amount of such payments received by the hospital  
8 under this Section in calendar year 2021, adjusted for  
9 increased funding provided for fixed pool directed  
10 payments under subsection (g) in calendar year 2022,  
11 assuming that the volume and acuity of claims are held  
12 constant. The Department shall publish the directed  
13 payment amounts to be established under this subsection on  
14 its website by November 15, 2022.

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

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

22 Notwithstanding any other provision of this subsection, if  
23 the Department determines that the actual total hospital  
24 utilization data that is used to calculate the fixed rate  
25 directed payments is substantially different than anticipated  
26 when the rates in this subsection were initially determined

1 for unforeseeable circumstances (such as the COVID-19 pandemic  
2 or some other public health emergency), the Department may  
3 adjust the rates specified in this subsection so that the  
4 total directed payments approximate the total spending amount  
5 anticipated when the rates were initially established.

6 Definitions. As used in this subsection:

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

9 (B) "Determination Quarter" means each calendar  
10 quarter which ends 3 months prior to the first day of  
11 each Payout Quarter.

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

25 (i) Beginning January 1, 2021, the rates for directed  
26 payments shall be recalculated in order to spend the

1 additional funds for directed payments that result from  
2 reduction in the amount of pass-through payments allowed under  
3 federal regulations. The additional funds for directed  
4 payments shall be allocated proportionally to each class of  
5 hospitals based on that class' proportion of services.

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

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

1 calendar year.

2 (j) Pass-through payments.

3 (1) For the period July 1, 2020 through December 31,  
4 2020, the Department shall assign quarterly pass-through  
5 payments to each class of hospitals equal to one-fourth of  
6 the following annual allocations:

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

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

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

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

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

12 (F) \$40,825,444 to freestanding psychiatric  
13 hospitals.

14 (G) \$9,652,108 to freestanding rehabilitation  
15 hospitals.

16 (2) For the period of July 1, 2020 through December  
17 31, 2020, the pass-through payments shall at a minimum  
18 ensure hospitals receive a total amount of monthly  
19 payments under this Section as received in calendar year  
20 2019 in accordance with this Article and paragraph (1) of  
21 subsection (d-5) of Section 14-12, exclusive of amounts  
22 received through payments referenced in subsection (b).

23 (3) For the calendar year beginning January 1, 2023,  
24 the Department shall establish the annual pass-through  
25 allocation to each class of hospitals and the pass-through  
26 payments to each hospital so that the total amount of

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

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

24 (k) At least 30 days prior to each calendar year, the  
25 Department shall notify each hospital of changes to the  
26 payment methodologies in this Section, including, but not

1 limited to, changes in the fixed rate directed payment rates,  
2 the aggregate pass-through payment amount for all hospitals,  
3 and the hospital's pass-through payment amount for the  
4 upcoming calendar year.

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

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

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

1 receiving hospital, with the distribution of funding to be  
2 established by rule and with consideration to perinatal  
3 hospitals with safe birthing levels and quality metrics for  
4 healthy mothers and babies.

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

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

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

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

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

4 (4) \$673,860,000 to general acute care hospitals.

5 (5) \$48,330,000 to long term acute care hospitals.

6 (6) \$89,110,000 to freestanding psychiatric hospitals.

7 (7) \$24,300,000 to freestanding rehabilitation  
8 hospitals.

9 (8) \$32,570,000 to public hospitals.

10 (q) Hospital Pandemic Recovery Stabilization Payments. The  
11 Department shall disburse a pool of \$460,000,000 in stability  
12 payments to hospitals prior to April 1, 2023. The allocation  
13 of the pool shall be based on the hospital directed payment  
14 classes and directed payments issued, during Calendar Year  
15 2022 with added consideration to safety net hospitals, as  
16 defined in subdivision (f)(1)(B) of this Section, and critical  
17 access hospitals.

18 (Source: P.A. 102-4, eff. 4-27-21; 102-16, eff. 6-17-21;  
19 102-886, eff. 5-17-22; 102-1115, eff. 1-9-23; 103-102, eff.  
20 6-16-23; 103-593, eff. 6-7-24; 103-605, eff. 7-1-24.)