



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

HB5442

Introduced 2/13/2026, by Rep. Norine K. Hammond

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5A-12.7

Amends the Hospital Provider Funding Article of the Illinois Public Aid Code. In provisions requiring the Department to establish the fixed pool directed payment amounts for specific classes of hospitals listed in the Code, provides that, beginning January 1, 2027, the Department of Healthcare and Family Services shall remove from the list the following hospital classes: (i) hospital inpatient services for public hospitals and (ii) hospital outpatient services for public hospitals. Requires the Department to instead, subject to any necessary federal approval, enter into intergovernmental agreements with the respective governing bodies to ensure continued access for those services in rural areas of the State. Provides that the Department shall reinstate the described hospital classes if federal approval is not received. Effective January 1, 2027.

LRB104 20236 KTG 33687 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 Sec. 5A-12.7. Continuation of hospital access payments on  
8 and after July 1, 2020.

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

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

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

8 (c) Graduate medical education.

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

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

25 (3) An annualized Medicaid indirect medical education  
26 (IME) payment is calculated for each hospital using its

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

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

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

26                   (B) Beginning January 1, 2023, the applicable

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

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

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

24 (2) For safety-net hospitals, \$960 per covered  
25 inpatient day contained in paid fee-for-service claims and  
26 \$625 per paid fee-for-service outpatient claim for dates

1 of service in Calendar Year 2019 in the Department's  
2 Enterprise Data Warehouse as of May 11, 2020.

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

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

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

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

23 (7) Alzheimer's treatment access payment. Each  
24 Illinois academic medical center or teaching hospital, as  
25 defined in Section 5-5e.2 of this Code, that is identified  
26 as the primary hospital affiliate of one of the Regional

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

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

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

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

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

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

24           (5) For freestanding rehabilitation hospitals, \$550  
25 per covered inpatient day contained in paid  
26 fee-for-service claims and \$125 per paid fee-for-service

1 outpatient claim for dates of service in Calendar Year  
2 2019 in the Department's Enterprise Data Warehouse as of  
3 August 6, 2021.

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

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

17 (8) Alzheimer's treatment access payment. Each  
18 Illinois academic medical center or teaching hospital, as  
19 defined in Section 5-5e.2 of this Code, that is identified  
20 as the primary hospital affiliate of one of the Regional  
21 Alzheimer's Disease Assistance Centers, as designated by  
22 the Alzheimer's Disease Assistance Act and identified in  
23 the Department of Public Health's Alzheimer's Disease  
24 State Plan dated December 2016, shall be paid an  
25 Alzheimer's treatment access payment equal to the product  
26 of the qualifying hospital's Calendar Year 2019 total

1 inpatient fee-for-service days, in the Department's  
2 Enterprise Data Warehouse as of August 6, 2021, multiplied  
3 by the applicable Alzheimer's treatment rate of \$244.37  
4 for hospitals located in Cook County and \$312.03 for  
5 hospitals located outside Cook County.

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

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

25 (f)(1) For purposes of allocating the funds included in  
26 capitation payments to MCOs, Illinois hospitals shall be

1 divided into the following classes as defined in  
2 administrative rules:

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

9 (B) Safety-net hospitals, except that stand-alone  
10 children's hospitals that are not specialty children's  
11 hospitals, safety-net hospitals that elect not to be  
12 included as provided in item (i), and, for calendar years  
13 2025 and 2026 only, hospitals with over 9,000 Medicaid  
14 acute care inpatient admissions per calendar year,  
15 excluding admissions for Medicare-Medicaid dual eligible  
16 patients, will not be included. For the calendar year  
17 beginning January 1, 2023, and each calendar year  
18 thereafter, assignment to the safety-net class shall be  
19 based on the annual safety-net rate year beginning 15  
20 months before the beginning of the first Payout Quarter of  
21 the calendar year.

22 (i) Beginning calendar year 2026, all hospitals  
23 qualifying as a safety-net hospital under subsection  
24 (a) of Section 5-5e.1 for rates years beginning on and  
25 after October 1, 2024 shall be permitted to elect to  
26 remain in the high Medicaid hospital class as defined

1 in subparagraph (G) for purposes of the State directed  
2 payments described in subsection (r) instead of being  
3 assigned to the safety-net fixed pool directed  
4 payments class as described in subsection (g).

5 (ii) If a hospital elects assignment in the high  
6 Medicaid hospital class as defined in subparagraph  
7 (G), the hospital must remain in the high Medicaid  
8 hospital class for the entire calendar year.

9 (C) Long term acute care hospitals.

10 (D) Freestanding psychiatric hospitals.

11 (E) Freestanding rehabilitation hospitals.

12 (F) Beginning January 1, 2023, "public hospital" means  
13 a hospital that is owned or operated by an Illinois  
14 Government body or municipality, excluding a hospital  
15 provider that is a State agency, a State university, or a  
16 county with a population of 3,000,000 or more.

17 (G) High Medicaid hospitals.

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

20 (I) For the payout periods July 1, 2020  
21 through December 31, 2022, is not a safety-net  
22 hospital or critical access hospital and that has  
23 a Medicaid Inpatient Utilization Rate above 30% or  
24 a hospital that had over 35,000 inpatient Medicaid  
25 days during the applicable period. For the period  
26 July 1, 2020 through December 31, 2020, the

1 applicable period for the Medicaid Inpatient  
2 Utilization Rate (MIUR) is the rate year 2020 MIUR  
3 and for the number of inpatient days it is State  
4 fiscal year 2018. Beginning in calendar year 2021,  
5 the Department shall use the most recently  
6 determined MIUR, as defined in subsection (h) of  
7 Section 5-5.02, and for the inpatient day  
8 threshold, the State fiscal year ending 18 months  
9 prior to the beginning of the calendar year. For  
10 purposes of calculating MIUR under this Section,  
11 children's hospitals and affiliated general acute  
12 care hospitals shall be considered a single  
13 hospital.

14 (II) For the calendar year beginning January  
15 1, 2023, and each calendar year thereafter, is not  
16 a public hospital, safety-net hospital, or  
17 critical access hospital and that qualifies as a  
18 regional high volume hospital or is a hospital  
19 that has a Medicaid Inpatient Utilization Rate  
20 (MIUR) above 30%. As used in this item, "regional  
21 high volume hospital" means a hospital which ranks  
22 in the top 2 quartiles based on total hospital  
23 services volume, of all eligible general acute  
24 care hospitals, when ranked in descending order  
25 based on total hospital services volume, within  
26 the same Medicaid managed care region, as

1 designated by the Department, as of January 1,  
2 2022. As used in this item, "total hospital  
3 services volume" means the total of all Medical  
4 Assistance hospital inpatient admissions plus all  
5 Medical Assistance hospital outpatient visits. For  
6 purposes of determining regional high volume  
7 hospital inpatient admissions and outpatient  
8 visits, the Department shall use dates of service  
9 provided during State Fiscal Year 2020 for the  
10 Payout Quarter beginning January 1, 2023. The  
11 Department shall use dates of service from the  
12 State fiscal year ending 18 month before the  
13 beginning of the first Payout Quarter of the  
14 subsequent annual determination period.

15 (ii) For the calendar year beginning January 1,  
16 2023, the Department shall use the Rate Year 2022  
17 Medicaid inpatient utilization rate (MIUR), as defined  
18 in subsection (h) of Section 5-5.02. For each  
19 subsequent annual determination, the Department shall  
20 use the MIUR applicable to the rate year ending  
21 September 30 of the year preceding the beginning of  
22 the calendar year.

23 (H) General acute care hospitals. As used under this  
24 Section, "general acute care hospitals" means all other  
25 Illinois hospitals not identified in subparagraphs (A)  
26 through (G).

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

6           (3) Beginning January 1, 2024, the Department may reassign  
7 hospitals or entire hospital classes as defined above, if  
8 federal limits on the payments to the class to which the  
9 hospitals are assigned based on the criteria in this  
10 subsection prevent the Department from making payments to the  
11 class that would otherwise be due under this Section. The  
12 Department shall publish the criteria and composition of each  
13 new class based on the reassignments, and the projected impact  
14 on payments to each hospital under the new classes on its  
15 website by November 15 of the year before the year in which the  
16 class changes become effective.

17           (g) Fixed pool directed payments. Beginning July 1, 2020,  
18 the Department shall issue payments to MCOs which shall be  
19 used to issue directed payments to qualified Illinois  
20 safety-net hospitals and critical access hospitals on a  
21 monthly basis in accordance with this subsection. Prior to the  
22 beginning of each Payout Quarter beginning July 1, 2020, the  
23 Department shall use encounter claims data from the  
24 Determination Quarter, accepted by the Department's Medicaid  
25 Management Information System for inpatient and outpatient  
26 services rendered by safety-net hospitals and critical access

1 hospitals to determine a quarterly uniform per unit add-on for  
2 each hospital class.

3 (1) Inpatient per unit add-on. A quarterly uniform per  
4 diem add-on shall be derived by dividing the quarterly  
5 Inpatient Directed Payments Pool amount allocated to the  
6 applicable hospital class by the total inpatient days  
7 contained on all encounter claims received during the  
8 Determination Quarter, for all hospitals in the class.

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

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

20 (2) Outpatient per unit add-on. A quarterly uniform  
21 per claim add-on shall be derived by dividing the  
22 quarterly Outpatient Directed Payments Pool amount  
23 allocated to the applicable hospital class by the total  
24 outpatient encounter claims received during the  
25 Determination Quarter, for all hospitals in the class.

26 (A) Each hospital in the class shall have a

1           quarterly outpatient directed payment calculated that  
2           is equal to the product of the number of outpatient  
3           encounter claims attributable to the hospital used in  
4           the calculation of the quarterly uniform class per  
5           claim add-on, multiplied by the calculated applicable  
6           quarterly uniform class per claim add-on of the  
7           hospital class.

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

12          (3) Each MCO shall pay each hospital the Monthly  
13          Directed Payment as identified by the Department on its  
14          quarterly determination report.

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

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

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

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

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

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

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

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

7 (6) For the period January 1, 2023 through December  
8 31, 2023, the Department shall establish the amounts that  
9 shall be allocated to the hospital class directed payment  
10 fixed pools identified in this paragraph for the quarterly  
11 development of a uniform per unit add-on. The Department  
12 shall establish such amounts so that the total amount of  
13 payments to each hospital under this Section in calendar  
14 year 2023 is projected to be substantially similar to the  
15 total amount of such payments received by the hospital  
16 under this Section in calendar year 2021, adjusted for  
17 increased funding provided for fixed pool directed  
18 payments under subsection (g) in calendar year 2022,  
19 assuming that the volume and acuity of claims are held  
20 constant. The Department shall publish the directed  
21 payment fixed pool amounts to be established under this  
22 paragraph on its website by November 15, 2022. Beginning  
23 January 1, 2027, the Department shall remove the hospital  
24 classes described in subparagraphs (C) and (D) and  
25 instead, subject to any necessary federal approval, enter  
26 into intergovernmental agreements with the respective

1 governing bodies to ensure continued access for those  
2 services in rural areas of the State. The Department shall  
3 reinstate the hospital classes described in subparagraphs  
4 (C) and (D) if approval is not received for such  
5 reimbursement by the federal Centers for Medicare and  
6 Medicaid Services.

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. The funding shall be used to  
21 preserve or enhance OB/GYN services or other specialty  
22 services at the receiving hospital, with the distribution of  
23 funding to be established by rule and with consideration to  
24 perinatal hospitals with safe birthing levels and quality  
25 metrics for healthy mothers and babies.

26 (o) In order to address the growing challenges of

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

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

- 22 (1) \$858,260,000 to safety-net hospitals.
- 23 (2) \$86,200,000 to critical access hospitals.
- 24 (3) \$1,765,000,000 to high Medicaid hospitals.
- 25 (4) \$673,860,000 to general acute care hospitals.
- 26 (5) \$48,330,000 to long term acute care hospitals.

1 (6) \$89,110,000 to freestanding psychiatric hospitals.

2 (7) \$24,300,000 to freestanding rehabilitation  
3 hospitals.

4 (8) \$32,570,000 to public hospitals.

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

13 (r) Directed payment update. For calendar year 2025, and  
14 each calendar year thereafter, the final amounts, rates, and  
15 payments for the fixed pool directed payments described in  
16 subsection (g) and the fixed rate directed payments described  
17 in subsection (h) shall be established by the Department at no  
18 less than the following:

19 (1) \$579,261,585 for inpatient services at safety-net  
20 hospitals.

21 (2) \$763,418,138 for outpatient services at safety-net  
22 hospitals.

23 (3) \$12,389,160 for inpatient services at critical  
24 access hospitals.

25 (4) \$137,437,866 for outpatient services at critical  
26 access hospitals.

1           (5) \$5,418 as a base fixed rate per admit prior to  
2           adjusting for acuity, for inpatient services at high  
3           Medicaid hospitals.

4           (6) \$1,512 as a base fixed rate per paid E-APG prior to  
5           adjusting for acuity, for outpatient services at high  
6           Medicaid hospitals.

7           (7) \$3,898 as a base fixed rate per admit prior to  
8           adjusting for acuity, for inpatient services at other  
9           acute care hospitals.

10          (8) \$1,322 as a base fixed rate per E-APG prior to  
11          adjusting for acuity, for outpatient services at other  
12          acute hospitals.

13          (9) \$773 per day for inpatient services at long term  
14          acute care hospitals.

15          (10) \$206 per day for inpatient services at  
16          freestanding psychiatric hospitals.

17          (11) \$223 per claim for outpatient services at  
18          freestanding psychiatric hospitals.

19          (12) \$776 per day for inpatient services at  
20          freestanding rehabilitation hospitals.

21          (13) \$252 per claim for outpatient services at  
22          freestanding rehabilitation hospitals.

23          ~~(14) \$7,793,812 for inpatient services at public~~  
24          ~~hospitals.~~

25          ~~(15) \$26,849,592 for outpatient services at public~~  
26          ~~hospitals.~~

1           Implementation of the rate increases described in this  
2 subsection (r) shall be contingent on federal approval. The  
3 rates for fixed pool directed payments as described in  
4 subsection (g) and for fixed rate directed payments as  
5 described in subsection (h) shall remain as published by the  
6 Department on November 27, 2024 until the Department receives  
7 federal approval for the updated rates described in this  
8 subsection (r).

9           (s) If, in order to secure approval by the Centers for  
10 Medicare and Medicaid Services, the rates under subsection (r)  
11 are reduced, the Department may submit a State Plan amendment  
12 to increase rates in place at the time of the reduction  
13 pertaining to subsection (d-2) to offset the annual amount of  
14 reduction to the rates under subsection (r), in amounts equal  
15 to the required reduction on a class-specific basis to ensure  
16 that funds are not reallocated from one class to another; or  
17 the rates in subsection (r) shall be reduced uniformly to the  
18 amounts necessary to achieve approval and the assessments  
19 imposed by subsection (a) or (b-5) of Section 5A-2 shall be  
20 reduced uniformly to achieve a total annual reduction across  
21 both assessments equal to the product of the total annual  
22 reduction to payments and .3853. In addition, the assessments  
23 shall further be reduced uniformly to achieve a total annual  
24 reduction across both assessments equal to the difference of  
25 subtracting the product calculated in the previous sentence  
26 from the resulting quotient of dividing the product described

1 in the previous sentence by .92 for a reduction to the  
2 transfers in subsection 7.16 and 7.17 of Section 5A-8.

3 (t) To provide for the expeditious and timely  
4 implementation of the changes made to this Section by this  
5 amendatory Act of the 104th General Assembly, the Department  
6 may adopt emergency rules as authorized by Section 5-45 of the  
7 Illinois Administrative Procedure Act. The adoption of  
8 emergency rules is deemed to be necessary for the public  
9 interest, safety, and welfare.

10 (Source: P.A. 103-102, eff. 6-16-23; 103-593, eff. 6-7-24;  
11 103-605, eff. 7-1-24; 104-7, eff. 6-16-25.)

12 Section 99. Effective date. This Act takes effect January  
13 1, 2027.