



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5509

Introduced 2/13/2026, by Rep. Hoan Huynh

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5A-12.7

Amends the Hospital Provider Funding Article of the Illinois Public Aid Code. Provides that, beginning January 1, 2027, if an Illinois freestanding psychiatric hospital reopens a previously closed hospital facility within 4 calendar years of that hospital facility's closure, and the previously closed hospital facility qualified for fee-for-service supplemental payments, then the Illinois freestanding psychiatric hospital shall receive an annual payment equal to \$200 per covered inpatient day contained in paid fee-for-service claims and \$200 per paid fee-for-service outpatient claim for dates of service of the closed hospital facility in Calendar Year 2019 in the Department of Healthcare and Family Services' Enterprise Data Warehouse as of May 11, 2020. Provides that "closed hospital facility" includes hospitals that have been terminated from participation in the medical assistance program. Effective immediately.

LRB104 20560 KTG 34039 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 (d-3) Fee-for-service supplemental payments. Beginning
7 January 1, 2027, if an Illinois freestanding psychiatric
8 hospital reopens a previously closed hospital facility within
9 4 calendar years of that hospital facility's closure, and the
10 previously closed hospital facility qualified for payments
11 under paragraph (d), then the Illinois freestanding
12 psychiatric hospital shall receive an annual payment equal to
13 \$200 per covered inpatient day contained in paid
14 fee-for-service claims and \$200 per paid fee-for-service
15 outpatient claim for dates of service of the closed hospital
16 facility in Calendar Year 2019 in the Department's Enterprise
17 Data Warehouse as of May 11, 2020. As used in this subsection,
18 "closed hospital facility" includes hospitals that have been
19 terminated from participation in the medical assistance
20 program in accordance with Section 12-4.25 of this Code.

21 (e) The Department shall require managed care
22 organizations (MCOs) to make directed payments and
23 pass-through payments according to this Section. Each calendar
24 year, the Department shall require MCOs to pay the maximum
25 amount out of these funds as allowed as pass-through payments
26 under federal regulations. The Department shall require MCOs

1 to make such pass-through payments as specified in this
2 Section. The Department shall require the MCOs to pay the
3 remaining amounts as directed Payments as specified in this
4 Section. The Department shall issue payments to the
5 Comptroller by the seventh business day of each month for all
6 MCOs that are sufficient for MCOs to make the directed
7 payments and pass-through payments according to this Section.
8 The Department shall require the MCOs to make pass-through
9 payments and directed payments using electronic funds
10 transfers (EFT), if the hospital provides the information
11 necessary to process such EFTs, in accordance with directions
12 provided monthly by the Department, within 7 business days of
13 the date the funds are paid to the MCOs, as indicated by the
14 "Paid Date" on the website of the Office of the Comptroller if
15 the funds are paid by EFT and the MCOs have received directed
16 payment instructions. If funds are not paid through the
17 Comptroller by EFT, payment must be made within 7 business
18 days of the date actually received by the MCO. The MCO will be
19 considered to have paid the pass-through payments when the
20 payment remittance number is generated or the date the MCO
21 sends the check to the hospital, if EFT information is not
22 supplied. If an MCO is late in paying a pass-through payment or
23 directed payment as required under this Section (including any
24 extensions granted by the Department), it shall pay a penalty,
25 unless waived by the Department for reasonable cause, to the
26 Department equal to 5% of the amount of the pass-through

1 payment or directed payment not paid on or before the due date
2 plus 5% of the portion thereof remaining unpaid on the last day
3 of each 30-day period thereafter. Payments to MCOs that would
4 be paid consistent with actuarial certification and enrollment
5 in the absence of the increased capitation payments under this
6 Section shall not be reduced as a consequence of payments made
7 under this subsection. The Department shall publish and
8 maintain on its website for a period of no less than 8 calendar
9 quarters, the quarterly calculation of directed payments and
10 pass-through payments owed to each hospital from each MCO. All
11 calculations and reports shall be posted no later than the
12 first day of the quarter for which the payments are to be
13 issued.

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

18 (A) Beginning July 1, 2020 through December 31, 2022,
19 critical access hospitals. Beginning January 1, 2023,
20 "critical access hospital" means a hospital designated by
21 the Department of Public Health as a critical access
22 hospital, excluding any hospital meeting the definition of
23 a public hospital in subparagraph (F).

24 (B) Safety-net hospitals, except that stand-alone
25 children's hospitals that are not specialty children's
26 hospitals, safety-net hospitals that elect not to be

1 included as provided in item (i), and, for calendar years
2 2025 and 2026 only, hospitals with over 9,000 Medicaid
3 acute care inpatient admissions per calendar year,
4 excluding admissions for Medicare-Medicaid dual eligible
5 patients, will not be included. For the calendar year
6 beginning January 1, 2023, and each calendar year
7 thereafter, assignment to the safety-net class shall be
8 based on the annual safety-net rate year beginning 15
9 months before the beginning of the first Payout Quarter of
10 the calendar year.

11 (i) Beginning calendar year 2026, all hospitals
12 qualifying as a safety-net hospital under subsection
13 (a) of Section 5-5e.1 for rates years beginning on and
14 after October 1, 2024 shall be permitted to elect to
15 remain in the high Medicaid hospital class as defined
16 in subparagraph (G) for purposes of the State directed
17 payments described in subsection (r) instead of being
18 assigned to the safety-net fixed pool directed
19 payments class as described in subsection (g).

20 (ii) If a hospital elects assignment in the high
21 Medicaid hospital class as defined in subparagraph
22 (G), the hospital must remain in the high Medicaid
23 hospital class for the entire calendar year.

24 (C) Long term acute care hospitals.

25 (D) Freestanding psychiatric hospitals.

26 (E) Freestanding rehabilitation hospitals.

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

6 (G) High Medicaid hospitals.

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

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

1 care hospitals shall be considered a single
2 hospital.

3 (II) For the calendar year beginning January
4 1, 2023, and each calendar year thereafter, is not
5 a public hospital, safety-net hospital, or
6 critical access hospital and that qualifies as a
7 regional high volume hospital or is a hospital
8 that has a Medicaid Inpatient Utilization Rate
9 (MIUR) above 30%. As used in this item, "regional
10 high volume hospital" means a hospital which ranks
11 in the top 2 quartiles based on total hospital
12 services volume, of all eligible general acute
13 care hospitals, when ranked in descending order
14 based on total hospital services volume, within
15 the same Medicaid managed care region, as
16 designated by the Department, as of January 1,
17 2022. As used in this item, "total hospital
18 services volume" means the total of all Medical
19 Assistance hospital inpatient admissions plus all
20 Medical Assistance hospital outpatient visits. For
21 purposes of determining regional high volume
22 hospital inpatient admissions and outpatient
23 visits, the Department shall use dates of service
24 provided during State Fiscal Year 2020 for the
25 Payout Quarter beginning January 1, 2023. The
26 Department shall use dates of service from the

1 State fiscal year ending 18 month before the
2 beginning of the first Payout Quarter of the
3 subsequent annual determination period.

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

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

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

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

1 Department shall publish the criteria and composition of each
2 new class based on the reassignments, and the projected impact
3 on payments to each hospital under the new classes on its
4 website by November 15 of the year before the year in which the
5 class changes become effective.

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

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

24 (A) Each hospital in the class shall have a
25 quarterly inpatient directed payment calculated that
26 is equal to the product of the number of inpatient days

1 attributable to the hospital used in the calculation
2 of the quarterly uniform class per diem add-on,
3 multiplied by the calculated applicable quarterly
4 uniform class per diem add-on of the hospital class.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 shall 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 fixed pool amounts to be established under this
11 paragraph on its website by November 15, 2022.

12 (A) Hospital inpatient services for critical
13 access hospitals.

14 (B) Hospital outpatient services for critical
15 access hospitals.

16 (C) Hospital inpatient services for public
17 hospitals.

18 (D) Hospital outpatient services for public
19 hospitals.

20 (E) Hospital inpatient services for safety-net
21 hospitals.

22 (F) Hospital outpatient services for safety-net
23 hospitals.

24 (7) Semi-annual rate maintenance review. The
25 Department shall ensure that hospitals assigned to the
26 fixed pools in paragraph (6) are paid no less than 95% of

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

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

23 (B) If the effective rate calculated in
24 subparagraph (A) is less than 95% of the annual
25 initial rate assigned to the class for each pool under
26 paragraph (6), the Department shall adjust the payment

1 for each hospital to a level equal to no less than 95%
2 of the annual initial rate, by issuing a retroactive
3 adjustment payment for the 6-month period under review
4 as identified in subparagraph (A).

5 (h) Fixed rate directed payments. Effective July 1, 2020,
6 the Department shall issue payments to MCOs which shall be
7 used to issue directed payments to Illinois hospitals not
8 identified in paragraph (g) on a monthly basis. 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 hospitals in each hospital class
14 identified in paragraph (f) and not identified in paragraph
15 (g). For the period July 1, 2020 through December 2020, the
16 Department shall direct MCOs to make payments as follows:

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

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

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

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

11 (5) For general acute care hospitals an amount equal
12 to \$240 multiplied by the hospital's category of service
13 27 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 (6) For general acute care hospitals an amount equal
18 to \$290 multiplied by the hospital's category of service
19 29 case mix index for the determination quarter multiplied
20 by the hospital's total number of category of service 29
21 paid EAPGs for the determination quarter.

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

1 (8) For high Medicaid hospitals an amount equal to
2 \$160 multiplied by the hospital's category of service 21
3 case mix index for the determination quarter multiplied by
4 the hospital's total number of inpatient admissions for
5 category of service 21 for the determination quarter.

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

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

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

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

1 (13) For long term acute care hospitals the amount of
2 \$495 multiplied by the hospital's total number of
3 inpatient days for the determination quarter.

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

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

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

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

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

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

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

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

24 Notwithstanding any other provision of this subsection, if
25 the Department determines that the actual total hospital
26 utilization data that is used to calculate the fixed rate

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

8 Definitions. As used in this subsection:

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

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

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

1 (i) Beginning January 1, 2021, the rates for directed
2 payments shall be recalculated in order to spend the
3 additional funds for directed payments that result from
4 reduction in the amount of pass-through payments allowed under
5 federal regulations. The additional funds for directed
6 payments shall be allocated proportionally to each class of
7 hospitals based on that class' proportion of services.

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

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

1 payments for the hospitals comprising the hospital fixed
2 rate directed payment class paid during the preceding
3 calendar year.

4 (j) Pass-through payments.

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

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

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

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

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

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

14 (F) \$40,825,444 to freestanding psychiatric
15 hospitals.

16 (G) \$9,652,108 to freestanding rehabilitation
17 hospitals.

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

25 (3) For the calendar year beginning January 1, 2023,
26 the Department shall establish the annual pass-through

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

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

26 (k) At least 30 days prior to each calendar year, the

1 Department shall notify each hospital of changes to the
2 payment methodologies in this Section, including, but not
3 limited to, changes in the fixed rate directed payment rates,
4 the aggregate pass-through payment amount for all hospitals,
5 and the hospital's pass-through payment amount for the
6 upcoming calendar year.

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

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

20 (n) In order to address the escalating infant mortality
21 rates among minority communities in Illinois, the State shall,
22 subject to appropriation, create a pool of funding of at least
23 \$50,000,000 annually to be disbursed among safety-net
24 hospitals that maintain perinatal designation from the
25 Department of Public Health. The funding shall be used to
26 preserve or enhance OB/GYN services or other specialty

1 services at the receiving hospital, with the distribution of
2 funding to be established by rule and with consideration to
3 perinatal hospitals with safe birthing levels and quality
4 metrics for 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 (r) Directed payment update. For calendar year 2025, and
19 each calendar year thereafter, the final amounts, rates, and
20 payments for the fixed pool directed payments described in
21 subsection (g) and the fixed rate directed payments described
22 in subsection (h) shall be established by the Department at no
23 less than the following:

- 24 (1) \$579,261,585 for inpatient services at safety-net
- 25 hospitals.
- 26 (2) \$763,418,138 for outpatient services at safety-net

1 hospitals.

2 (3) \$12,389,160 for inpatient services at critical
3 access hospitals.

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

6 (5) \$5,418 as a base fixed rate per admit prior to
7 adjusting for acuity, for inpatient services at high
8 Medicaid hospitals.

9 (6) \$1,512 as a base fixed rate per paid E-APG prior to
10 adjusting for acuity, for outpatient services at high
11 Medicaid hospitals.

12 (7) \$3,898 as a base fixed rate per admit prior to
13 adjusting for acuity, for inpatient services at other
14 acute care hospitals.

15 (8) \$1,322 as a base fixed rate per E-APG prior to
16 adjusting for acuity, for outpatient services at other
17 acute hospitals.

18 (9) \$773 per day for inpatient services at long term
19 acute care hospitals.

20 (10) \$206 per day for inpatient services at
21 freestanding psychiatric hospitals.

22 (11) \$223 per claim for outpatient services at
23 freestanding psychiatric hospitals.

24 (12) \$776 per day for inpatient services at
25 freestanding rehabilitation hospitals.

26 (13) \$252 per claim for outpatient services at

1 freestanding rehabilitation hospitals.

2 (14) \$7,793,812 for inpatient services at public
3 hospitals.

4 (15) \$26,849,592 for outpatient services at public
5 hospitals.

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

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

1 reduction to payments and .3853. In addition, the assessments
2 shall further be reduced uniformly to achieve a total annual
3 reduction across both assessments equal to the difference of
4 subtracting the product calculated in the previous sentence
5 from the resulting quotient of dividing the product described
6 in the previous sentence by .92 for a reduction to the
7 transfers in subsection 7.16 and 7.17 of Section 5A-8.

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

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

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