

1 AN ACT concerning health.

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

4 Section 5. The Illinois Administrative Procedure Act is  
5 amended by adding Section 5-45.65 as follows:

6 (5 ILCS 100/5-45.65 new)

7 Sec. 5-45.65. Emergency rulemaking; Medicaid reimbursement  
8 rates for hospital inpatient and outpatient services. To  
9 provide for the expeditious and timely implementation of the  
10 changes made by this amendatory Act of the 104th General  
11 Assembly to Sections 5A-2, 5A-7, 5A-8, 5A-10, and 5A-12.7 of  
12 the Illinois Public Aid Code, emergency rules implementing the  
13 changes made by this amendatory Act of the 104th General  
14 Assembly to Sections 5A-2, 5A-7, 5A-8, 5A-10, and 5A-12.7 of  
15 the Illinois Public Aid Code may be adopted in accordance with  
16 Section 5-45 by the Department of Healthcare and Family  
17 Services. The adoption of emergency rules authorized by  
18 Section 5-45 and this Section is deemed necessary for the  
19 public interest, safety, and welfare.

20 This Section is repealed one year after the effective date  
21 of this amendatory Act of the 104th General Assembly.

22 Section 10. The Illinois Public Aid Code is amended by

1 changing Sections 5A-2, 5A-5, 5A-7, 5A-8, 5A-10, 5A-12.7,  
2 5A-14, and 12-4.105 as follows:

3 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

4 (Section scheduled to be repealed on December 31, 2026)

5 Sec. 5A-2. Assessment.

6 (a) (1) Subject to Sections 5A-3 and 5A-10, for State  
7 fiscal years 2009 through 2018, or as long as continued under  
8 Section 5A-16, an annual assessment on inpatient services is  
9 imposed on each hospital provider in an amount equal to  
10 \$218.38 multiplied by the difference of the hospital's  
11 occupied bed days less the hospital's Medicare bed days,  
12 provided, however, that the amount of \$218.38 shall be  
13 increased by a uniform percentage to generate an amount equal  
14 to 75% of the State share of the payments authorized under  
15 Section 5A-12.5, with such increase only taking effect upon  
16 the date that a State share for such payments is required under  
17 federal law. For the period of April through June 2015, the  
18 amount of \$218.38 used to calculate the assessment under this  
19 paragraph shall, by emergency rule under subsection (s) of  
20 Section 5-45 of the Illinois Administrative Procedure Act, be  
21 increased by a uniform percentage to generate \$20,250,000 in  
22 the aggregate for that period from all hospitals subject to  
23 the annual assessment under this paragraph.

24 (2) In addition to any other assessments imposed under  
25 this Article, effective July 1, 2016 and semi-annually

1 thereafter through June 2018, or as provided in Section 5A-16,  
2 in addition to any federally required State share as  
3 authorized under paragraph (1), the amount of \$218.38 shall be  
4 increased by a uniform percentage to generate an amount equal  
5 to 75% of the ACA Assessment Adjustment, as defined in  
6 subsection (b-6) of this Section.

7 For State fiscal years 2009 through 2018, or as provided  
8 in Section 5A-16, a hospital's occupied bed days and Medicare  
9 bed days shall be determined using the most recent data  
10 available from each hospital's 2005 Medicare cost report as  
11 contained in the Healthcare Cost Report Information System  
12 file, for the quarter ending on December 31, 2006, without  
13 regard to any subsequent adjustments or changes to such data.  
14 If a hospital's 2005 Medicare cost report is not contained in  
15 the Healthcare Cost Report Information System, then the  
16 Illinois Department may obtain the hospital provider's  
17 occupied bed days and Medicare bed days from any source  
18 available, including, but not limited to, records maintained  
19 by the hospital provider, which may be inspected at all times  
20 during business hours of the day by the Illinois Department or  
21 its duly authorized agents and employees.

22 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
23 fiscal years 2019 and 2020, an annual assessment on inpatient  
24 services is imposed on each hospital provider in an amount  
25 equal to \$197.19 multiplied by the difference of the  
26 hospital's occupied bed days less the hospital's Medicare bed

1 days. For State fiscal years 2019 and 2020, a hospital's  
2 occupied bed days and Medicare bed days shall be determined  
3 using the most recent data available from each hospital's 2015  
4 Medicare cost report as contained in the Healthcare Cost  
5 Report Information System file, for the quarter ending on  
6 March 31, 2017, without regard to any subsequent adjustments  
7 or changes to such data. If a hospital's 2015 Medicare cost  
8 report is not contained in the Healthcare Cost Report  
9 Information System, then the Illinois Department may obtain  
10 the hospital provider's occupied bed days and Medicare bed  
11 days from any source available, including, but not limited to,  
12 records maintained by the hospital provider, which may be  
13 inspected at all times during business hours of the day by the  
14 Illinois Department or its duly authorized agents and  
15 employees. Notwithstanding any other provision in this  
16 Article, for a hospital provider that did not have a 2015  
17 Medicare cost report, but paid an assessment in State fiscal  
18 year 2018 on the basis of hypothetical data, that assessment  
19 amount shall be used for State fiscal years 2019 and 2020.

20 (4) Subject to Sections 5A-3 and 5A-10 and to subsection  
21 (b-8), for the period of July 1, 2020 through December 31, 2020  
22 and calendar years 2021 through 2024 ~~2026~~, an annual  
23 assessment on inpatient services is imposed on each hospital  
24 provider in an amount equal to \$221.50 multiplied by the  
25 difference of the hospital's occupied bed days less the  
26 hospital's Medicare bed days, provided however: for the period

1 of July 1, 2020 through December 31, 2020, (i) the assessment  
2 shall be equal to 50% of the annual amount; and (ii) the amount  
3 of \$221.50 shall be retroactively adjusted by a uniform  
4 percentage to generate an amount equal to 50% of the  
5 Assessment Adjustment, as defined in subsection (b-7). For the  
6 period of July 1, 2020 through December 31, 2020 and calendar  
7 years 2021 through 2024 ~~2026~~, a hospital's occupied bed days  
8 and Medicare bed days shall be determined using the most  
9 recent data available from each hospital's 2015 Medicare cost  
10 report as contained in the Healthcare Cost Report Information  
11 System file, for the quarter ending on March 31, 2017, without  
12 regard to any subsequent adjustments or changes to such data.  
13 If a hospital's 2015 Medicare cost report is not contained in  
14 the Healthcare Cost Report Information System, then the  
15 Illinois Department may obtain the hospital provider's  
16 occupied bed days and Medicare bed days from any source  
17 available, including, but not limited to, records maintained  
18 by the hospital provider, which may be inspected at all times  
19 during business hours of the day by the Illinois Department or  
20 its duly authorized agents and employees. Should the change in  
21 the assessment methodology for fiscal years 2021 through  
22 December 31, 2022 not be approved on or before June 30, 2020,  
23 the assessment and payments under this Article in effect for  
24 fiscal year 2020 shall remain in place until the new  
25 assessment is approved. If the assessment methodology for July  
26 1, 2020 through December 31, 2022, is approved on or after July

1 1, 2020, it shall be retroactive to July 1, 2020, subject to  
2 federal approval and provided that the payments authorized  
3 under Section 5A-12.7 have the same effective date as the new  
4 assessment methodology. In giving retroactive effect to the  
5 assessment approved after June 30, 2020, credit toward the new  
6 assessment shall be given for any payments of the previous  
7 assessment for periods after June 30, 2020. Notwithstanding  
8 any other provision of this Article, for a hospital provider  
9 that did not have a 2015 Medicare cost report, but paid an  
10 assessment in State Fiscal Year 2020 on the basis of  
11 hypothetical data, the data that was the basis for the 2020  
12 assessment shall be used to calculate the assessment under  
13 this paragraph until December 31, 2023. Beginning July 1, 2022  
14 and through December 31, 2024, a safety-net hospital that had  
15 a change of ownership in calendar year 2021, and whose  
16 inpatient utilization had decreased by 90% from the prior year  
17 and prior to the change of ownership, may be eligible to pay a  
18 tax based on hypothetical data based on a determination of  
19 financial distress by the Department. Subject to federal  
20 approval, the Department may, by January 1, 2024, develop a  
21 hypothetical tax for a specialty cancer hospital which had a  
22 structural change of ownership during calendar year 2022 from  
23 a for-profit entity to a non-profit entity, and which has  
24 experienced a decline of 60% or greater in inpatient days of  
25 care as compared to the prior owners 2015 Medicare cost  
26 report. This change of ownership may make the hospital

1 eligible for a hypothetical tax under the new hospital  
2 provision of the assessment defined in this Section. This new  
3 hypothetical tax may be applicable from January 1, 2024  
4 through December 31, 2026.

5 (5) Subject to Sections 5A-3 and 5A-10, beginning January  
6 1, 2025, an annual assessment on inpatient services is imposed  
7 on each hospital provider in an amount equal to \$362, or any  
8 reduction thereof in accordance with this subsection,  
9 multiplied by the difference of the hospital's occupied bed  
10 days less the hospital's Medicare bed days; however, the rate  
11 shall be \$221.50 until the Department receives federal  
12 approval and implements the reimbursement rates in subsection  
13 (r) of Section 5A-12.7. The Department may bill for the  
14 difference between the assessment rate of \$362, or any  
15 reduction thereof in accordance with this subsection, and  
16 \$221.50 no earlier than 17 calendar days after implementing  
17 the reimbursement rates in subsection (r) of Section 5A-12.7.

18 (A) Upon receiving federal approval for the  
19 reimbursement rates in subsection (r) of Section 5A-12.7,  
20 the Department shall bill the hospital for the incremental  
21 difference in total tax due resulting from the increase  
22 provided in this subsection for the number of months from  
23 January 1, 2025 through the date of federal approval. The  
24 amount shall be due and payable no later than December 31,  
25 2025 and no earlier than 17 calendar days after  
26 implementing the reimbursement rates in subsection (r) of

1 Section 5A-12.7. The Department shall bill hospitals in  
2 the same proportional rate as the Department has  
3 implemented the inpatient reimbursement rates in  
4 subsection (r) of Section 5A-12.7.

5 (B) Beginning January 1, 2025, a hospital's occupied  
6 bed days and Medicare bed days shall be determined using  
7 the most recent data available from each hospital's 2015  
8 Medicare cost report as contained in the Healthcare Cost  
9 Report Information System file, for the quarter ending on  
10 March 31, 2017, without regard to any subsequent  
11 adjustments or changes to such data. If a hospital's 2015  
12 Medicare cost report is not contained in the Healthcare  
13 Cost Report Information System, then the Department may  
14 obtain the hospital provider's occupied bed days and  
15 Medicare bed days from any source available, including,  
16 but not limited to, records maintained by the hospital  
17 provider, which may be inspected at all times during  
18 business hours of the day by the Department or its duly  
19 authorized agents and employees. If the reimbursement  
20 rates in subsection (r) of Section 5A-12.7 require  
21 reduction to comply with federal spending limits, then the  
22 tax rate of \$362 shall be reduced, in accordance with  
23 subsection (s) of Section 5A-12.7, by the same percentage  
24 reduction to payments required to comply with federal  
25 spending limits.

26 (b) (Blank).

1 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the  
2 portion of State fiscal year 2012, beginning June 10, 2012  
3 through June 30, 2012, and for State fiscal years 2013 through  
4 2018, or as provided in Section 5A-16, an annual assessment on  
5 outpatient services is imposed on each hospital provider in an  
6 amount equal to .008766 multiplied by the hospital's  
7 outpatient gross revenue, provided, however, that the amount  
8 of .008766 shall be increased by a uniform percentage to  
9 generate an amount equal to 25% of the State share of the  
10 payments authorized under Section 5A-12.5, with such increase  
11 only taking effect upon the date that a State share for such  
12 payments is required under federal law. For the period  
13 beginning June 10, 2012 through June 30, 2012, the annual  
14 assessment on outpatient services shall be prorated by  
15 multiplying the assessment amount by a fraction, the numerator  
16 of which is 21 days and the denominator of which is 365 days.  
17 For the period of April through June 2015, the amount of  
18 .008766 used to calculate the assessment under this paragraph  
19 shall, by emergency rule under subsection (s) of Section 5-45  
20 of the Illinois Administrative Procedure Act, be increased by  
21 a uniform percentage to generate \$6,750,000 in the aggregate  
22 for that period from all hospitals subject to the annual  
23 assessment under this paragraph.

24 (2) In addition to any other assessments imposed under  
25 this Article, effective July 1, 2016 and semi-annually  
26 thereafter through June 2018, in addition to any federally

1 required State share as authorized under paragraph (1), the  
2 amount of .008766 shall be increased by a uniform percentage  
3 to generate an amount equal to 25% of the ACA Assessment  
4 Adjustment, as defined in subsection (b-6) of this Section.

5 For the portion of State fiscal year 2012, beginning June  
6 10, 2012 through June 30, 2012, and State fiscal years 2013  
7 through 2018, or as provided in Section 5A-16, a hospital's  
8 outpatient gross revenue shall be determined using the most  
9 recent data available from each hospital's 2009 Medicare cost  
10 report as contained in the Healthcare Cost Report Information  
11 System file, for the quarter ending on June 30, 2011, without  
12 regard to any subsequent adjustments or changes to such data.  
13 If a hospital's 2009 Medicare cost report is not contained in  
14 the Healthcare Cost Report Information System, then the  
15 Department may obtain the hospital provider's outpatient gross  
16 revenue from any source available, including, but not limited  
17 to, records maintained by the hospital provider, which may be  
18 inspected at all times during business hours of the day by the  
19 Department or its duly authorized agents and employees.

20 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State  
21 fiscal years 2019 and 2020, an annual assessment on outpatient  
22 services is imposed on each hospital provider in an amount  
23 equal to .01358 multiplied by the hospital's outpatient gross  
24 revenue. For State fiscal years 2019 and 2020, a hospital's  
25 outpatient gross revenue shall be determined using the most  
26 recent data available from each hospital's 2015 Medicare cost

1 report as contained in the Healthcare Cost Report Information  
2 System file, for the quarter ending on March 31, 2017, without  
3 regard to any subsequent adjustments or changes to such data.  
4 If a hospital's 2015 Medicare cost report is not contained in  
5 the Healthcare Cost Report Information System, then the  
6 Department may obtain the hospital provider's outpatient gross  
7 revenue from any source available, including, but not limited  
8 to, records maintained by the hospital provider, which may be  
9 inspected at all times during business hours of the day by the  
10 Department or its duly authorized agents and employees.  
11 Notwithstanding any other provision in this Article, for a  
12 hospital provider that did not have a 2015 Medicare cost  
13 report, but paid an assessment in State fiscal year 2018 on the  
14 basis of hypothetical data, that assessment amount shall be  
15 used for State fiscal years 2019 and 2020.

16 (4) Subject to Sections 5A-3 and 5A-10 and to subsection  
17 (b-8), for the period of July 1, 2020 through December 31, 2020  
18 and calendar years 2021 through 2024 ~~2026~~, an annual  
19 assessment on outpatient services is imposed on each hospital  
20 provider in an amount equal to .01525 multiplied by the  
21 hospital's outpatient gross revenue, provided however: (i) for  
22 the period of July 1, 2020 through December 31, 2020, the  
23 assessment shall be equal to 50% of the annual amount; and (ii)  
24 the amount of .01525 shall be retroactively adjusted by a  
25 uniform percentage to generate an amount equal to 50% of the  
26 Assessment Adjustment, as defined in subsection (b-7). For the

1 period of July 1, 2020 through December 31, 2020 and calendar  
2 years 2021 through 2024 ~~2026~~, a hospital's outpatient gross  
3 revenue shall be determined using the most recent data  
4 available from each hospital's 2015 Medicare cost report as  
5 contained in the Healthcare Cost Report Information System  
6 file, for the quarter ending on March 31, 2017, without regard  
7 to any subsequent adjustments or changes to such data. If a  
8 hospital's 2015 Medicare cost report is not contained in the  
9 Healthcare Cost Report Information System, then the Illinois  
10 Department may obtain the hospital provider's outpatient  
11 revenue data from any source available, including, but not  
12 limited to, records maintained by the hospital provider, which  
13 may be inspected at all times during business hours of the day  
14 by the Illinois Department or its duly authorized agents and  
15 employees. Should the change in the assessment methodology  
16 above for fiscal years 2021 through calendar year 2022 not be  
17 approved prior to July 1, 2020, the assessment and payments  
18 under this Article in effect for fiscal year 2020 shall remain  
19 in place until the new assessment is approved. If the change in  
20 the assessment methodology above for July 1, 2020 through  
21 December 31, 2022, is approved after June 30, 2020, it shall  
22 have a retroactive effective date of July 1, 2020, subject to  
23 federal approval and provided that the payments authorized  
24 under Section 12A-7 have the same effective date as the new  
25 assessment methodology. In giving retroactive effect to the  
26 assessment approved after June 30, 2020, credit toward the new

1 assessment shall be given for any payments of the previous  
2 assessment for periods after June 30, 2020. Notwithstanding  
3 any other provision of this Article, for a hospital provider  
4 that did not have a 2015 Medicare cost report, but paid an  
5 assessment in State Fiscal Year 2020 on the basis of  
6 hypothetical data, the data that was the basis for the 2020  
7 assessment shall be used to calculate the assessment under  
8 this paragraph until December 31, 2023. Beginning July 1, 2022  
9 and through December 31, 2024, a safety-net hospital that had  
10 a change of ownership in calendar year 2021, and whose  
11 inpatient utilization had decreased by 90% from the prior year  
12 and prior to the change of ownership, may be eligible to pay a  
13 tax based on hypothetical data based on a determination of  
14 financial distress by the Department.

15 (5) Subject to Sections 5A-3 and 5A-10, beginning January  
16 1, 2025, an annual assessment on outpatient services is  
17 imposed on each hospital provider in an amount equal to  
18 .03273, or any reduction thereof in accordance with this  
19 subsection, multiplied by the hospital's outpatient gross  
20 revenue; however the rate shall remain .01525, until the  
21 Department receives federal approval and implements the  
22 reimbursement rates of payment in subsection (r) of Section  
23 5A-12.7. The Department may bill for the difference between  
24 the assessment multiplier of .03273 and .01525 no earlier than  
25 17 calendar days after the first payment based on the  
26 reimbursement rates in subsection (r) of Section 5A-12.7.

1           (A) Upon receiving federal approval for the  
2           reimbursement rates in subsection (r) of Section 5A-12.7,  
3           the Department shall bill the hospital for the incremental  
4           difference in total tax due resulting from the increase  
5           provided in this subsection for the number of months from  
6           January 1, 2025 through the date of federal approval. The  
7           amount shall be due and payable no later than December 31,  
8           2025 and no earlier than 17 calendar days after  
9           implementing the reimbursement rates in subsection (r) of  
10           Section 5A-12.7. The Department shall bill hospitals in  
11           the same proportional rate as the Department has  
12           implemented the outpatient reimbursement rates in  
13           subsection (r) of Section 5A-12.7.

14           (B) Beginning January 1, 2025, a hospital's outpatient  
15           gross revenue shall be determined using the most recent  
16           data available from each hospital's 2015 Medicare cost  
17           report as contained in the Healthcare Cost Report  
18           Information System file, for the quarter ending on March  
19           31, 2017, without regard to any subsequent adjustments or  
20           changes to such data. If a hospital's 2015 Medicare cost  
21           report is not contained in the Healthcare Cost Report  
22           Information System, then the Department may obtain the  
23           hospital provider's outpatient revenue data from any  
24           source available, including, but not limited to, records  
25           maintained by the hospital provider, which may be  
26           inspected at all times during business hours of the day by

1 the Department or its duly authorized agents and  
2 employees. If the reimbursement rates in subsection (r) of  
3 Section 5A-12.7 require reduction to comply with federal  
4 spending limits, then the tax rate of .03273 shall be  
5 reduced, in accordance with subsection (s) of Section  
6 5A-12.7, by the same percentage reduction to payments  
7 required to comply with federal spending limits.

8 (b-6) (1) As used in this Section, "ACA Assessment  
9 Adjustment" means:

10 (A) For the period of July 1, 2016 through December  
11 31, 2016, the product of .19125 multiplied by the sum of  
12 the fee-for-service payments to hospitals as authorized  
13 under Section 5A-12.5 and the adjustments authorized under  
14 subsection (t) of Section 5A-12.2 to managed care  
15 organizations for hospital services due and payable in the  
16 month of April 2016 multiplied by 6.

17 (B) For the period of January 1, 2017 through June 30,  
18 2017, the product of .19125 multiplied by the sum of the  
19 fee-for-service payments to hospitals as authorized under  
20 Section 5A-12.5 and the adjustments authorized under  
21 subsection (t) of Section 5A-12.2 to managed care  
22 organizations for hospital services due and payable in the  
23 month of October 2016 multiplied by 6, except that the  
24 amount calculated under this subparagraph (B) shall be  
25 adjusted, either positively or negatively, to account for  
26 the difference between the actual payments issued under

1 Section 5A-12.5 for the period beginning July 1, 2016  
2 through December 31, 2016 and the estimated payments due  
3 and payable in the month of April 2016 multiplied by 6 as  
4 described in subparagraph (A).

5 (C) For the period of July 1, 2017 through December  
6 31, 2017, the product of .19125 multiplied by the sum of  
7 the fee-for-service payments to hospitals as authorized  
8 under Section 5A-12.5 and the adjustments authorized under  
9 subsection (t) of Section 5A-12.2 to managed care  
10 organizations for hospital services due and payable in the  
11 month of April 2017 multiplied by 6, except that the  
12 amount calculated under this subparagraph (C) shall be  
13 adjusted, either positively or negatively, to account for  
14 the difference between the actual payments issued under  
15 Section 5A-12.5 for the period beginning January 1, 2017  
16 through June 30, 2017 and the estimated payments due and  
17 payable in the month of October 2016 multiplied by 6 as  
18 described in subparagraph (B).

19 (D) For the period of January 1, 2018 through June 30,  
20 2018, the product of .19125 multiplied by the sum of the  
21 fee-for-service payments to hospitals as authorized under  
22 Section 5A-12.5 and the adjustments authorized under  
23 subsection (t) of Section 5A-12.2 to managed care  
24 organizations for hospital services due and payable in the  
25 month of October 2017 multiplied by 6, except that:

26 (i) the amount calculated under this subparagraph

1 (D) shall be adjusted, either positively or  
2 negatively, to account for the difference between the  
3 actual payments issued under Section 5A-12.5 for the  
4 period of July 1, 2017 through December 31, 2017 and  
5 the estimated payments due and payable in the month of  
6 April 2017 multiplied by 6 as described in  
7 subparagraph (C); and

8 (ii) the amount calculated under this subparagraph  
9 (D) shall be adjusted to include the product of .19125  
10 multiplied by the sum of the fee-for-service payments,  
11 if any, estimated to be paid to hospitals under  
12 subsection (b) of Section 5A-12.5.

13 (2) The Department shall complete and apply a final  
14 reconciliation of the ACA Assessment Adjustment prior to June  
15 30, 2018 to account for:

16 (A) any differences between the actual payments issued  
17 or scheduled to be issued prior to June 30, 2018 as  
18 authorized in Section 5A-12.5 for the period of January 1,  
19 2018 through June 30, 2018 and the estimated payments due  
20 and payable in the month of October 2017 multiplied by 6 as  
21 described in subparagraph (D); and

22 (B) any difference between the estimated  
23 fee-for-service payments under subsection (b) of Section  
24 5A-12.5 and the amount of such payments that are actually  
25 scheduled to be paid.

26 The Department shall notify hospitals of any additional

1 amounts owed or reduction credits to be applied to the June  
2 2018 ACA Assessment Adjustment. This is to be considered the  
3 final reconciliation for the ACA Assessment Adjustment.

4 (3) Notwithstanding any other provision of this Section,  
5 if for any reason the scheduled payments under subsection (b)  
6 of Section 5A-12.5 are not issued in full by the final day of  
7 the period authorized under subsection (b) of Section 5A-12.5,  
8 funds collected from each hospital pursuant to subparagraph  
9 (D) of paragraph (1) and pursuant to paragraph (2),  
10 attributable to the scheduled payments authorized under  
11 subsection (b) of Section 5A-12.5 that are not issued in full  
12 by the final day of the period attributable to each payment  
13 authorized under subsection (b) of Section 5A-12.5, shall be  
14 refunded.

15 (4) The increases authorized under paragraph (2) of  
16 subsection (a) and paragraph (2) of subsection (b-5) shall be  
17 limited to the federally required State share of the total  
18 payments authorized under Section 5A-12.5 if the sum of such  
19 payments yields an annualized amount equal to or less than  
20 \$450,000,000, or if the adjustments authorized under  
21 subsection (t) of Section 5A-12.2 are found not to be  
22 actuarially sound; however, this limitation shall not apply to  
23 the fee-for-service payments described in subsection (b) of  
24 Section 5A-12.5.

25 (b-7) (1) As used in this Section, "Assessment Adjustment"  
26 means:

1           (A) For the period of July 1, 2020 through December  
2           31, 2020, the product of .3853 multiplied by the total of  
3           the actual payments made under subsections (c) through (k)  
4           of Section 5A-12.7 attributable to the period, less the  
5           total of the assessment imposed under subsections (a) and  
6           (b-5) of this Section for the period.

7           (B) For each calendar quarter beginning January 1,  
8           2021 through December 31, 2022, the product of .3853  
9           multiplied by the total of the actual payments made under  
10          subsections (c) through (k) of Section 5A-12.7  
11          attributable to the period, less the total of the  
12          assessment imposed under subsections (a) and (b-5) of this  
13          Section for the period.

14          (C) Beginning on January 1, 2023, and each subsequent  
15          July 1 and January 1, the product of .3853 multiplied by  
16          the total of the actual payments made under subsections  
17          (c) through (j) and subsection (r) of Section 5A-12.7  
18          attributable to the 6-month period immediately preceding  
19          the period to which the adjustment applies, less the total  
20          of the assessment imposed under subsections (a) and (b-5)  
21          of this Section for the 6-month period immediately  
22          preceding the period to which the adjustment applies.

23          (2) The Department shall calculate and notify each  
24          hospital of the total Assessment Adjustment and any additional  
25          assessment owed by the hospital or refund owed to the hospital  
26          on either a semi-annual or annual basis. Such notice shall be

1 issued at least 30 days prior to any period in which the  
2 assessment will be adjusted. Any additional assessment owed by  
3 the hospital or refund owed to the hospital shall be uniformly  
4 applied to the assessment owed by the hospital in monthly  
5 installments for the subsequent semi-annual period or calendar  
6 year. If no assessment is owed in the subsequent year, any  
7 amount owed by the hospital or refund due to the hospital,  
8 shall be paid in a lump sum. If the calculation that is  
9 computed under this Section could result in a decrease in the  
10 Department's federal financial participation percentage for  
11 payments authorized under Section 5A-12.7, then the Department  
12 shall instead apply a uniform percentage reduction to the  
13 payment rates outlined in subsection (r) of Section 5A-12.7  
14 for all classes as defined in subsections (g) and (h) of  
15 Section 5A-12.7 by an amount no more than necessary to  
16 maximize federal reimbursement.

17 (3) The Department shall publish all details of the  
18 Assessment Adjustment calculation performed each year on its  
19 website within 30 days of completing the calculation, and also  
20 submit the details of the Assessment Adjustment calculation as  
21 part of the Department's annual report to the General  
22 Assembly.

23 (b-8) Notwithstanding any other provision of this Article,  
24 the Department shall reduce the assessments imposed on each  
25 hospital under subsections (a) and (b-5) by the uniform  
26 percentage necessary to reduce the total assessment imposed on

1 all hospitals by an aggregate amount of \$240,000,000, with  
2 such reduction being applied by June 30, 2022. The assessment  
3 reduction required for each hospital under this subsection  
4 shall be forever waived, forgiven, and released by the  
5 Department.

6 (c) (Blank).

7 (d) Notwithstanding any of the other provisions of this  
8 Section, the Department is authorized to adopt rules to reduce  
9 the rate of any annual assessment imposed under this Section,  
10 as authorized by Section 5-46.2 of the Illinois Administrative  
11 Procedure Act.

12 (e) Notwithstanding any other provision of this Section,  
13 any plan providing for an assessment on a hospital provider as  
14 a permissible tax under Title XIX of the federal Social  
15 Security Act and Medicaid-eligible payments to hospital  
16 providers from the revenues derived from that assessment shall  
17 be reviewed by the Illinois Department of Healthcare and  
18 Family Services, as the Single State Medicaid Agency required  
19 by federal law, to determine whether those assessments and  
20 hospital provider payments meet federal Medicaid standards. If  
21 the Department determines that the elements of the plan may  
22 meet federal Medicaid standards and a related State Medicaid  
23 Plan Amendment is prepared in a manner and form suitable for  
24 submission, that State Plan Amendment shall be submitted in a  
25 timely manner for review by the Centers for Medicare and  
26 Medicaid Services of the United States Department of Health

1 and Human Services and subject to approval by the Centers for  
2 Medicare and Medicaid Services of the United States Department  
3 of Health and Human Services. No such plan shall become  
4 effective without approval by the Illinois General Assembly by  
5 the enactment into law of related legislation. Notwithstanding  
6 any other provision of this Section, the Department is  
7 authorized to adopt rules to reduce the rate of any annual  
8 assessment imposed under this Section. Any such rules may be  
9 adopted by the Department under Section 5-50 of the Illinois  
10 Administrative Procedure Act.

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

18 (Source: P.A. 102-886, eff. 5-17-22; 103-102, eff. 1-1-24.)

19 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)

20 Sec. 5A-5. Notice; penalty; maintenance of records.

21 (a) The Illinois Department shall send a notice of  
22 assessment to every hospital provider subject to assessment  
23 under this Article. The notice of assessment shall notify the  
24 hospital of its assessment and shall be sent after receipt by  
25 the Department of notification from the Centers for Medicare

1 and Medicaid Services of the U.S. Department of Health and  
2 Human Services that the payment methodologies required under  
3 this Article and, if necessary, the waiver granted under 42  
4 CFR 433.68 have been approved. The notice shall be on a form  
5 prepared by the Illinois Department and shall state the  
6 following:

7 (1) The name of the hospital provider.

8 (2) The address of the hospital provider's principal  
9 place of business from which the provider engages in the  
10 occupation of hospital provider in this State, and the  
11 name and address of each hospital operated, conducted, or  
12 maintained by the provider in this State.

13 (3) The occupied bed days, occupied bed days less  
14 Medicare days, adjusted gross hospital revenue, or  
15 outpatient gross revenue of the hospital provider  
16 (whichever is applicable), the amount of assessment  
17 imposed under Section 5A-2 for the State fiscal year for  
18 which the notice is sent, and the amount of each  
19 installment to be paid during the State fiscal year.

20 (4) (Blank).

21 (5) Other reasonable information as determined by the  
22 Illinois Department.

23 (b) If a hospital provider conducts, operates, or  
24 maintains more than one hospital licensed by the Illinois  
25 Department of Public Health, the provider shall pay the  
26 assessment for each hospital separately.

1           (c) Notwithstanding any other provision in this Article,  
2 in the case of a person who ceases to conduct, operate, or  
3 maintain a hospital in respect of which the person is subject  
4 to assessment under this Article as a hospital provider, the  
5 assessment for the State fiscal year in which the cessation  
6 occurs shall be adjusted by multiplying the assessment  
7 computed under Section 5A-2 by a fraction, the numerator of  
8 which is the number of days in the year during which the  
9 provider conducts, operates, or maintains the hospital and the  
10 denominator of which is 365. Immediately upon ceasing to  
11 conduct, operate, or maintain a hospital, the person shall pay  
12 the assessment for the year as so adjusted (to the extent not  
13 previously paid).

14           (d) Notwithstanding any other provision in this Article, a  
15 provider who commences conducting, operating, or maintaining a  
16 hospital, upon notice by the Illinois Department, shall pay  
17 the assessment computed under Section 5A-2 and subsection (e)  
18 in installments on the due dates stated in the notice and on  
19 the regular installment due dates for the State fiscal year  
20 occurring after the due dates of the initial notice.

21           (e) Notwithstanding any other provision in this Article,  
22 for State fiscal years 2009 through 2018, in the case of a  
23 hospital provider that did not conduct, operate, or maintain a  
24 hospital in 2005, the assessment for that State fiscal year  
25 shall be computed on the basis of hypothetical occupied bed  
26 days for the full calendar year as determined by the Illinois

1 Department. Notwithstanding any other provision in this  
2 Article, for the portion of State fiscal year 2012 beginning  
3 June 10, 2012 through June 30, 2012, and for State fiscal years  
4 2013 through 2018, in the case of a hospital provider that did  
5 not conduct, operate, or maintain a hospital in 2009, the  
6 assessment under subsection (b-5) of Section 5A-2 for that  
7 State fiscal year shall be computed on the basis of  
8 hypothetical gross outpatient revenue for the full calendar  
9 year as determined by the Illinois Department.

10 Notwithstanding any other provision in this Article,  
11 beginning July 1, 2018 ~~through December 31, 2026~~, in the case  
12 of a hospital provider that did not conduct, operate, or  
13 maintain a hospital in the year that is the basis of the  
14 calculation of the assessment under this Article, the  
15 assessment under ~~paragraph (3) of~~ subsection (a) of Section  
16 5A-2 for the State fiscal year shall be computed on the basis  
17 of hypothetical occupied bed days for the full calendar year  
18 as determined by the Illinois Department, except that for a  
19 hospital provider that did not have a 2015 Medicare cost  
20 report, but paid an assessment in State fiscal year 2018 on the  
21 basis of hypothetical data, that assessment amount shall be  
22 used for State fiscal years 2019 and 2020; however, for State  
23 fiscal year 2020, the assessment amount shall be increased by  
24 the proportion that it represents of the total annual  
25 assessment that is generated from all hospitals in order to  
26 generate \$6,250,000 in the aggregate for that period from all

1 hospitals subject to the annual assessment under this  
2 paragraph.

3 Notwithstanding any other provision in this Article,  
4 beginning July 1, 2018 ~~through December 31, 2026~~, in the case  
5 of a hospital provider that did not conduct, operate, or  
6 maintain a hospital in the year that is the basis of the  
7 calculation of the assessment under this Article, the  
8 assessment under subsection (b-5) of Section 5A-2 for that  
9 State fiscal year shall be computed on the basis of  
10 hypothetical gross outpatient revenue for the full calendar  
11 year as determined by the Illinois Department, except that for  
12 a hospital provider that did not have a 2015 Medicare cost  
13 report, but paid an assessment in State fiscal year 2018 on the  
14 basis of hypothetical data, that assessment amount shall be  
15 used for State fiscal years 2019 and 2020; however, for State  
16 fiscal year 2020, the assessment amount shall be increased by  
17 the proportion that it represents of the total annual  
18 assessment that is generated from all hospitals in order to  
19 generate \$6,250,000 in the aggregate for that period from all  
20 hospitals subject to the annual assessment under this  
21 paragraph.

22 (f) Every hospital provider subject to assessment under  
23 this Article shall keep sufficient records to permit the  
24 determination of adjusted gross hospital revenue for the  
25 hospital's fiscal year. All such records shall be kept in the  
26 English language and shall, at all times during regular

1 business hours of the day, be subject to inspection by the  
2 Illinois Department or its duly authorized agents and  
3 employees.

4 (g) The Illinois Department may, by rule, provide a  
5 hospital provider a reasonable opportunity to request a  
6 clarification or correction of any clerical or computational  
7 errors contained in the calculation of its assessment, but  
8 such corrections shall not extend to updating the cost report  
9 information used to calculate the assessment.

10 (h) (Blank).

11 (Source: P.A. 102-886, eff. 5-17-22.)

12 (305 ILCS 5/5A-7) (from Ch. 23, par. 5A-7)

13 Sec. 5A-7. Administration; enforcement provisions.

14 (a) The Illinois Department shall establish and maintain a  
15 listing of all hospital providers appearing in the licensing  
16 records of the Illinois Department of Public Health, which  
17 shall show each provider's name and principal place of  
18 business and the name and address of each hospital operated,  
19 conducted, or maintained by the provider in this State. The  
20 listing shall also include the monthly assessment amounts owed  
21 for each hospital and any unpaid assessment liability greater  
22 than 90 days delinquent. The Illinois Department shall  
23 administer and enforce this Article and collect the  
24 assessments and penalty assessments imposed under this Article  
25 using procedures employed in its administration of this Code

1 generally. The Illinois Department, its Director, and every  
2 hospital provider subject to assessment under this Article  
3 shall have the following powers, duties, and rights:

4 (1) The Illinois Department may initiate either  
5 administrative or judicial proceedings, or both, to  
6 enforce provisions of this Article. Administrative  
7 enforcement proceedings initiated hereunder shall be  
8 governed by the Illinois Department's administrative  
9 rules. Judicial enforcement proceedings initiated  
10 hereunder shall be governed by the rules of procedure  
11 applicable in the courts of this State.

12 (2) (Blank). ~~No proceedings for collection, refund,~~  
13 ~~credit, or other adjustment of an assessment amount shall~~  
14 ~~be issued more than 3 years after the due date of the~~  
15 ~~assessment, except in the case of an extended period~~  
16 ~~agreed to in writing by the Illinois Department and the~~  
17 ~~hospital provider before the expiration of this limitation~~  
18 ~~period.~~

19 (3) Any unpaid assessment under this Article shall  
20 become a lien upon the assets of the hospital upon which it  
21 was assessed. If any hospital provider, outside the usual  
22 course of its business, sells or transfers the major part  
23 of any one or more of (A) the real property and  
24 improvements, (B) the machinery and equipment, or (C) the  
25 furniture or fixtures, of any hospital that is subject to  
26 the provisions of this Article, the seller or transferor

1 shall pay the Illinois Department the amount of any  
2 assessment, assessment penalty, and interest (if any) due  
3 from it under this Article up to the date of the sale or  
4 transfer. The Illinois Department may, in its discretion,  
5 foreclose on such a lien, but shall do so in a manner that  
6 is consistent with Section 5e of the Retailers' Occupation  
7 Tax Act. If the seller or transferor fails to pay any  
8 assessment, assessment penalty, and interest (if any) due,  
9 the purchaser or transferee of such asset shall be liable  
10 for the amount of the assessment, penalties, and interest  
11 (if any) up to the amount of the reasonable value of the  
12 property acquired by the purchaser or transferee. The  
13 purchaser or transferee shall continue to be liable until  
14 the purchaser or transferee pays the full amount of the  
15 assessment, penalties, and interest (if any) up to the  
16 amount of the reasonable value of the property acquired by  
17 the purchaser or transferee or until the purchaser or  
18 transferee receives from the Illinois Department a  
19 certificate showing that such assessment, penalty, and  
20 interest have been paid or a certificate from the Illinois  
21 Department showing that no assessment, penalty, or  
22 interest is due from the seller or transferor under this  
23 Article.

24 (4) Payments under this Article are not subject to the  
25 Illinois Prompt Payment Act. Credits or refunds shall not  
26 bear interest.

1 (b) In addition to any other remedy provided for and  
2 without sending a notice of assessment liability, the Illinois  
3 Department shall ~~may~~ collect an unpaid assessment by  
4 withholding, as payment of the assessment, reimbursements or  
5 other amounts otherwise payable by the Illinois Department to  
6 the hospital provider, including, but not limited to, payment  
7 amounts otherwise payable from a managed care organization  
8 performing duties under contract with the Illinois Department.

9 (1) The requirements of this subsection may be waived  
10 in instances when a disaster proclamation has been  
11 declared by the Governor. In such circumstances, a  
12 hospital must demonstrate temporary financial distress and  
13 establish an agreement with the Illinois Department  
14 specifying when repayment in full of all taxes owed will  
15 occur.

16 (2) The requirements of this subsection may be waived  
17 by the Illinois Department in instances when a hospital  
18 has entered into and remains in compliance with a  
19 repayment plan or a tax deferral plan. A repayment plan or  
20 tax deferral plan must be entered into no later than 30  
21 days after notice of an unpaid assessment payment. No  
22 repayment plan may exceed a period of 36 months. No tax  
23 deferral plan may exceed a period of 6 months, and  
24 repayment after the end of a tax deferral plan shall not  
25 exceed 36 months. Failure to remain in compliance with a  
26 repayment plan or tax deferral plan shall cause immediate

1 termination of such plan unless there is prior written  
2 consent from the Illinois Department for a period of  
3 non-compliance.

4 (3) Beginning September 1, 2025, the Illinois  
5 Department shall immediately collect all overdue unpaid  
6 assessments and penalties through the collection methods  
7 authorized under this Section, unless a repayment plan or  
8 tax deferral plan has already been agreed to by September  
9 1, 2025.

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

17 (Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04;  
18 94-242, eff. 7-18-05.)

19 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

20 Sec. 5A-8. Hospital Provider Fund.

21 (a) There is created in the State Treasury the Hospital  
22 Provider Fund. Interest earned by the Fund shall be credited  
23 to the Fund. The Fund shall not be used to replace any moneys  
24 appropriated to the Medicaid program by the General Assembly.

25 (b) The Fund is created for the purpose of receiving

1 moneys in accordance with Section 5A-6 and disbursing moneys  
2 only for the following purposes, notwithstanding any other  
3 provision of law:

4 (1) For making payments to hospitals as required under  
5 this Code, under the Children's Health Insurance Program  
6 Act, under the Covering ALL KIDS Health Insurance Act, and  
7 under the Long Term Acute Care Hospital Quality  
8 Improvement Transfer Program Act.

9 (2) For the reimbursement of moneys collected by the  
10 Illinois Department from hospitals or hospital providers  
11 through error or mistake in performing the activities  
12 authorized under this Code.

13 (3) For payment of administrative expenses incurred by  
14 the Illinois Department or its agent in performing  
15 activities under this Code, under the Children's Health  
16 Insurance Program Act, under the Covering ALL KIDS Health  
17 Insurance Act, and under the Long Term Acute Care Hospital  
18 Quality Improvement Transfer Program Act.

19 (4) For payments of any amounts which are reimbursable  
20 to the federal government for payments from this Fund  
21 which are required to be paid by State warrant.

22 (5) For making transfers, as those transfers are  
23 authorized in the proceedings authorizing debt under the  
24 Short Term Borrowing Act, but transfers made under this  
25 paragraph (5) shall not exceed the principal amount of  
26 debt issued in anticipation of the receipt by the State of

1 moneys to be deposited into the Fund.

2 (6) For making transfers to any other fund in the  
3 State treasury, but transfers made under this paragraph  
4 (6) shall not exceed the amount transferred previously  
5 from that other fund into the Hospital Provider Fund plus  
6 any interest that would have been earned by that fund on  
7 the monies that had been transferred.

8 (6.5) For making transfers to the Healthcare Provider  
9 Relief Fund, except that transfers made under this  
10 paragraph (6.5) shall not exceed \$60,000,000 in the  
11 aggregate.

12 (7) For making transfers not exceeding the following  
13 amounts, related to State fiscal years 2013 through 2018,  
14 to the following designated funds:

15	Health and Human Services Medicaid Trust	
16	Fund .....	\$20,000,000
17	Long-Term Care Provider Fund .....	\$30,000,000
18	General Revenue Fund .....	\$80,000,000.

19 Transfers under this paragraph shall be made within 7 days  
20 after the payments have been received pursuant to the  
21 schedule of payments provided in subsection (a) of Section  
22 5A-4.

23 (7.1) (Blank).

24 (7.5) (Blank).

25 (7.8) (Blank).

26 (7.9) (Blank).

1           (7.10) For State fiscal year 2014, for making  
2 transfers of the moneys resulting from the assessment  
3 under subsection (b-5) of Section 5A-2 and received from  
4 hospital providers under Section 5A-4 and transferred into  
5 the Hospital Provider Fund under Section 5A-6 to the  
6 designated funds not exceeding the following amounts in  
7 that State fiscal year:

8                   Healthcare Provider Relief Fund..... \$100,000,000

9           Transfers under this paragraph shall be made within 7  
10 days after the payments have been received pursuant to the  
11 schedule of payments provided in subsection (a) of Section  
12 5A-4.

13           The additional amount of transfers in this paragraph  
14 (7.10), authorized by Public Act 98-651, shall be made  
15 within 10 State business days after June 16, 2014 (the  
16 effective date of Public Act 98-651). That authority shall  
17 remain in effect even if Public Act 98-651 does not become  
18 law until State fiscal year 2015.

19           (7.10a) For State fiscal years 2015 through 2018, for  
20 making transfers of the moneys resulting from the  
21 assessment under subsection (b-5) of Section 5A-2 and  
22 received from hospital providers under Section 5A-4 and  
23 transferred into the Hospital Provider Fund under Section  
24 5A-6 to the designated funds not exceeding the following  
25 amounts related to each State fiscal year:

26                   Healthcare Provider Relief Fund..... \$50,000,000

1 Transfers under this paragraph shall be made within 7  
2 days after the payments have been received pursuant to the  
3 schedule of payments provided in subsection (a) of Section  
4 5A-4.

5 (7.11) (Blank).

6 (7.12) For State fiscal year 2013, for increasing by  
7 21/365ths the transfer of the moneys resulting from the  
8 assessment under subsection (b-5) of Section 5A-2 and  
9 received from hospital providers under Section 5A-4 for  
10 the portion of State fiscal year 2012 beginning June 10,  
11 2012 through June 30, 2012 and transferred into the  
12 Hospital Provider Fund under Section 5A-6 to the  
13 designated funds not exceeding the following amounts in  
14 that State fiscal year:

15 Healthcare Provider Relief Fund..... \$2,870,000

16 Since the federal Centers for Medicare and Medicaid  
17 Services approval of the assessment authorized under  
18 subsection (b-5) of Section 5A-2, received from hospital  
19 providers under Section 5A-4 and the payment methodologies  
20 to hospitals required under Section 5A-12.4 was not  
21 received by the Department until State fiscal year 2014  
22 and since the Department made retroactive payments during  
23 State fiscal year 2014 related to the referenced period of  
24 June 2012, the transfer authority granted in this  
25 paragraph (7.12) is extended through the date that is 10  
26 State business days after June 16, 2014 (the effective

1 date of Public Act 98-651).

2 (7.13) In addition to any other transfers authorized  
3 under this Section, for State fiscal years 2017 and 2018,  
4 for making transfers to the Healthcare Provider Relief  
5 Fund of moneys collected from the ACA Assessment  
6 Adjustment authorized under subsections (a) and (b-5) of  
7 Section 5A-2 and paid by hospital providers under Section  
8 5A-4 into the Hospital Provider Fund under Section 5A-6  
9 for each State fiscal year. Timing of transfers to the  
10 Healthcare Provider Relief Fund under this paragraph shall  
11 be at the discretion of the Department, but no less  
12 frequently than quarterly.

13 (7.14) For making transfers not exceeding the  
14 following amounts, related to State fiscal years 2019 and  
15 2020, to the following designated funds:

16	Health and Human Services Medicaid Trust	
17	Fund .....	\$20,000,000
18	Long-Term Care Provider Fund .....	\$30,000,000
19	Healthcare Provider Relief Fund....	\$325,000,000.

20 Transfers under this paragraph shall be made within 7  
21 days after the payments have been received pursuant to the  
22 schedule of payments provided in subsection (a) of Section  
23 5A-4.

24 (7.15) For making transfers not exceeding the  
25 following amounts, related to State fiscal years 2023  
26 through 2024 ~~2026~~, to the following designated funds:

1 Health and Human Services Medicaid Trust  
 2 Fund ..... \$20,000,000  
 3 Long-Term Care Provider Fund ..... \$30,000,000  
 4 Healthcare Provider Relief Fund..... \$365,000,000

5 (7.16) For making transfers not exceeding the  
 6 following amounts, related to July 1, 2024 ~~2026~~ to  
 7 December 31, 2024 ~~2026~~, to the following designated funds:

8 Health and Human Services Medicaid Trust  
 9 Fund ..... \$10,000,000  
 10 Long-Term Care Provider Fund ..... \$15,000,000  
 11 Healthcare Provider Relief Fund..... \$182,500,000

12 (7.17) For making transfers not exceeding the  
 13 following amounts, related to calendar years 2025 and each  
 14 calendar year thereafter, the following designated funds:

15 Health and Human Services Medicaid Trust  
 16 Fund ..... \$20,000,000  
 17 Long-Term Care Provider Fund ..... \$30,000,000  
 18 Healthcare Provider Relief Fund.... \$505,637,082;

19 however the amount shall remain \$365,000,000 until the  
 20 reimbursement rates described in subsection (r) of Section  
 21 5A-12.7 are fully implemented. If for any reason the  
 22 assessment imposed by subsection (a) or (b-5) of Section 5A-2  
 23 is reduced, the amount of \$505,637,082 shall be reduced by the  
 24 same percentage.

25 To provide for the expeditious and timely implementation  
 26 of the changes made to this subsection by this amendatory Act

1 of the 104th General Assembly, the Department may adopt  
2 emergency rules as authorized by Section 5-45 of the Illinois  
3 Administrative Procedure Act. The adoption of emergency rules  
4 is deemed to be necessary for the public interest, safety, and  
5 welfare.

6 (8) For making refunds to hospital providers pursuant  
7 to Section 5A-10.

8 (9) For making payment to capitated managed care  
9 organizations as described in subsections (s) and (t) of  
10 Section 5A-12.2, subsection (r) of Section 5A-12.6, and  
11 Section 5A-12.7 of this Code.

12 Disbursements from the Fund, other than transfers  
13 authorized under paragraphs (5) and (6) of this subsection,  
14 shall be by warrants drawn by the State Comptroller upon  
15 receipt of vouchers duly executed and certified by the  
16 Illinois Department.

17 (c) The Fund shall consist of the following:

18 (1) All moneys collected or received by the Illinois  
19 Department from the hospital provider assessment imposed  
20 by this Article.

21 (2) All federal matching funds received by the  
22 Illinois Department as a result of expenditures made by  
23 the Illinois Department that are attributable to moneys  
24 deposited in the Fund.

25 (3) Any interest or penalty levied in conjunction with  
26 the administration of this Article.

1           (3.5) As applicable, proceeds from surety bond  
2           payments payable to the Department as referenced in  
3           subsection (s) of Section 5A-12.2 of this Code.

4           (4) Moneys transferred from another fund in the State  
5           treasury.

6           (5) All other moneys received for the Fund from any  
7           other source, including interest earned thereon.

8           (d) (Blank).

9           (Source: P.A. 101-650, eff. 7-7-20; 102-886, eff. 5-17-22.)

10           (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

11           Sec. 5A-10. Applicability.

12           (a) The assessment imposed by subsection (a) of Section  
13           5A-2 shall cease to be imposed and the Department's obligation  
14           to make payments shall immediately cease, and any moneys  
15           remaining in the Fund shall be refunded to hospital providers  
16           in proportion to the amounts paid by them, if:

17           (1) The payments to hospitals required under this  
18           Article are not eligible for federal matching funds under  
19           Title XIX or XXI of the Social Security Act;

20           (2) For State fiscal years 2009 through 2018, and as  
21           provided in Section 5A-16, the Department of Healthcare  
22           and Family Services adopts any administrative rule change  
23           to reduce payment rates or alters any payment methodology  
24           that reduces any payment rates made to operating hospitals  
25           under the approved Title XIX or Title XXI State plan in

1 effect January 1, 2008 except for:

2 (A) any changes for hospitals described in  
3 subsection (b) of Section 5A-3;

4 (B) any rates for payments made under this Article  
5 V-A;

6 (C) any changes proposed in State plan amendment  
7 transmittal numbers 08-01, 08-02, 08-04, 08-06, and  
8 08-07;

9 (D) in relation to any admissions on or after  
10 January 1, 2011, a modification in the methodology for  
11 calculating outlier payments to hospitals for  
12 exceptionally costly stays, for hospitals reimbursed  
13 under the diagnosis-related grouping methodology in  
14 effect on July 1, 2011; provided that the Department  
15 shall be limited to one such modification during the  
16 36-month period after the effective date of this  
17 amendatory Act of the 96th General Assembly;

18 (E) any changes affecting hospitals authorized by  
19 Public Act 97-689;

20 (F) any changes authorized by Section 14-12 of  
21 this Code, or for any changes authorized under Section  
22 5A-15 of this Code; or

23 (G) any changes authorized under Section 5-5b.1.

24 (b) The assessment imposed by Section 5A-2 shall not take  
25 effect or shall cease to be imposed, and the Department's  
26 obligation to make payments shall immediately cease, if the

1 assessment is determined to be an impermissible tax under  
2 Title XIX of the Social Security Act. Moneys in the Hospital  
3 Provider Fund derived from assessments imposed prior thereto  
4 shall be disbursed in accordance with Section 5A-8 to the  
5 extent federal financial participation is not reduced due to  
6 the impermissibility of the assessments, and any remaining  
7 moneys shall be refunded to hospital providers in proportion  
8 to the amounts paid by them.

9 (c) The assessments imposed by subsection (b-5) of Section  
10 5A-2 shall not take effect or shall cease to be imposed, the  
11 Department's obligation to make payments shall immediately  
12 cease, and any moneys remaining in the Fund shall be refunded  
13 to hospital providers in proportion to the amounts paid by  
14 them, if the payments to hospitals required under Section  
15 5A-12.4 or Section 5A-12.6 are not eligible for federal  
16 matching funds under Title XIX of the Social Security Act.

17 (d) The assessments imposed by Section 5A-2 shall not take  
18 effect or shall cease to be imposed, the Department's  
19 obligation to make payments shall immediately cease, and any  
20 moneys remaining in the Fund shall be refunded to hospital  
21 providers in proportion to the amounts paid by them, if:

22 (1) for State fiscal years 2013 through 2018, and as  
23 provided in Section 5A-16, the Department reduces any  
24 payment rates to hospitals as in effect on May 1, 2012, or  
25 alters any payment methodology as in effect on May 1,  
26 2012, that has the effect of reducing payment rates to

1 hospitals, except for any changes affecting hospitals  
2 authorized in Public Act 97-689 and any changes authorized  
3 by Section 14-12 of this Code, and except for any changes  
4 authorized under Section 5A-15, and except for any changes  
5 authorized under Section 5-5b.1;

6 (2) for State fiscal years 2013 through 2018, and as  
7 provided in Section 5A-16, the Department reduces any  
8 supplemental payments made to hospitals below the amounts  
9 paid for services provided in State fiscal year 2011 as  
10 implemented by administrative rules adopted and in effect  
11 on or prior to June 30, 2011, except for any changes  
12 affecting hospitals authorized in Public Act 97-689 and  
13 any changes authorized by Section 14-12 of this Code, and  
14 except for any changes authorized under Section 5A-15, and  
15 except for any changes authorized under Section 5-5b.1; or

16 (3) for State fiscal years 2015 through 2018, and as  
17 provided in Section 5A-16, the Department reduces the  
18 overall effective rate of reimbursement to hospitals below  
19 the level authorized under Section 14-12 of this Code,  
20 except for any changes under Section 14-12 or Section  
21 5A-15 of this Code, and except for any changes authorized  
22 under Section 5-5b.1.

23 (e) In State fiscal year 2019 through State fiscal year  
24 2020, the assessments imposed under Section 5A-2 shall not  
25 take effect or shall cease to be imposed, the Department's  
26 obligation to make payments shall immediately cease, and any

1 moneys remaining in the Fund shall be refunded to hospital  
2 providers in proportion to the amounts paid by them, if:

3 (1) the payments to hospitals required under Section  
4 5A-12.6 are not eligible for federal matching funds under  
5 Title XIX of the Social Security Act; or

6 (2) the Department reduces the overall effective rate  
7 of reimbursement to hospitals below the level authorized  
8 under Section 14-12 of this Code, as in effect on December  
9 31, 2017, except for any changes authorized under Sections  
10 14-12 or Section 5A-15 of this Code, and except for any  
11 changes authorized under changes to Sections 5A-12.2,  
12 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by Public Act  
13 100-581.

14 (f) Beginning in State Fiscal Year 2021 through December  
15 31, 2024, the assessments imposed under Section 5A-2 shall not  
16 take effect or shall cease to be imposed, the Department's  
17 obligation to make payments shall immediately cease, and any  
18 moneys remaining in the Fund shall be refunded to hospital  
19 providers in proportion to the amounts paid by them, if:

20 (1) the payments to hospitals required under Section  
21 5A-12.7 are not eligible for federal matching funds under  
22 Title XIX of the Social Security Act; or

23 (2) the Department reduces the overall effective rate  
24 of reimbursement to hospitals below the level authorized  
25 under Section 14-12, as in effect on December 31, 2021,  
26 except for any changes authorized under Sections 14-12 or

1 5A-15, and except for any changes authorized under changes  
2 to Sections 5A-12.7 and 14-12 made by this amendatory Act  
3 of the 101st General Assembly, and except for any changes  
4 to Section 5A-12.7 made by this amendatory Act of the  
5 102nd General Assembly.

6 (g) Beginning January 1, 2025, the assessments imposed  
7 under Section 5A-2 shall not take effect or shall cease to be  
8 imposed, if:

9 (1) the payments to hospitals required under Section  
10 5A-12.7 are not eligible for federal matching funds under  
11 Title XIX of the Social Security Act; or

12 (2) the Department reduces the rates of reimbursement  
13 below the rates in effect December 31, 2024, resulting in  
14 an aggregate reduction below the levels of reimbursement  
15 for the 12-month period ending 6 months prior to the  
16 effective date of the proposed new rates.

17 (h) To provide for the expeditious and timely  
18 implementation of the changes made to this Section by this  
19 amendatory Act of the 104th General Assembly, the Department  
20 may adopt emergency rules as authorized by Section 5-45 of the  
21 Illinois Administrative Procedure Act. The adoption of  
22 emergency rules is deemed to be necessary for the public  
23 interest, safety, and welfare.

24 (Source: P.A. 101-650, eff. 7-7-20; 102-886, eff. 5-17-22.)

25 (305 ILCS 5/5A-12.7)

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

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

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

23 (b) Amounts moved into claims-based rates and distributed  
24 in accordance with Section 14-12 shall remain in those  
25 claims-based rates.

26 (c) Graduate medical education.

1           (1) The calculation of graduate medical education  
2           payments shall be based on the hospital's Medicare cost  
3           report ending in Calendar Year 2018, as reported in the  
4           Healthcare Cost Report Information System file, release  
5           date September 30, 2019. An Illinois hospital reporting  
6           intern and resident cost on its Medicare cost report shall  
7           be eligible for graduate medical education payments.

8           (2) Each hospital's annualized Medicaid Intern  
9           Resident Cost is calculated using annualized intern and  
10          resident total costs obtained from Worksheet B Part I,  
11          Columns 21 and 22 the sum of Lines 30-43, 50-76, 90-93,  
12          96-98, and 105-112 multiplied by the percentage that the  
13          hospital's Medicaid days (Worksheet S3 Part I, Column 7,  
14          Lines 2, 3, 4, 14, 16-18, and 32) comprise of the  
15          hospital's total days (Worksheet S3 Part I, Column 8,  
16          Lines 14, 16-18, and 32).

17          (3) An annualized Medicaid indirect medical education  
18          (IME) payment is calculated for each hospital using its  
19          IME payments (Worksheet E Part A, Line 29, Column 1)  
20          multiplied by the percentage that its Medicaid days  
21          (Worksheet S3 Part I, Column 7, Lines 2, 3, 4, 14, 16-18,  
22          and 32) comprise of its Medicare days (Worksheet S3 Part  
23          I, Column 6, Lines 2, 3, 4, 14, and 16-18).

24          (4) For each hospital, its annualized Medicaid Intern  
25          Resident Cost and its annualized Medicaid IME payment are  
26          summed, and, except as capped at 120% of the average cost

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

15 (A) For the period of July 1, 2020 through  
16 December 31, 2022, the applicable reimbursement factor  
17 shall be 22.6%.

18 (B) Beginning ~~For the period of~~ January 1, 2023  
19 ~~through December 31, 2026,~~ the applicable  
20 reimbursement factor shall be 35% for all qualified  
21 safety-net hospitals, as defined in Section 5-5e.1 of  
22 this Code, and all hospitals with 100 or more Full Time  
23 Equivalent Residents and Interns, as reported on the  
24 hospital's Medicare cost report ending in Calendar  
25 Year 2018, and for all other qualified hospitals the  
26 applicable reimbursement factor shall be 30%.

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

12 (1) For critical access hospitals, \$385 per covered  
13 inpatient day contained in paid fee-for-service claims and  
14 \$530 per paid fee-for-service outpatient claim for dates  
15 of service in Calendar Year 2019 in the Department's  
16 Enterprise Data Warehouse as of May 11, 2020.

17 (2) For safety-net hospitals, \$960 per covered  
18 inpatient day contained in paid fee-for-service claims and  
19 \$625 per paid fee-for-service outpatient claim for dates  
20 of service in Calendar Year 2019 in the Department's  
21 Enterprise Data Warehouse as of May 11, 2020.

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

26 (4) For freestanding psychiatric hospitals, \$125 per

1 covered inpatient day contained in paid fee-for-service  
2 claims and \$130 per paid fee-for-service outpatient claim  
3 for dates of service in Calendar Year 2019 in the  
4 Department's Enterprise Data Warehouse as of May 11, 2020.

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

10 (6) For all general acute care hospitals and high  
11 Medicaid hospitals as defined in subsection (f), \$350 per  
12 covered inpatient day for dates of service in Calendar  
13 Year 2019 contained in paid fee-for-service claims and  
14 \$620 per paid fee-for-service outpatient claim in the  
15 Department's Enterprise Data Warehouse as of May 11, 2020.

16 (7) Alzheimer's treatment access payment. Each  
17 Illinois academic medical center or teaching hospital, as  
18 defined in Section 5-5e.2 of this Code, that is identified  
19 as the primary hospital affiliate of one of the Regional  
20 Alzheimer's Disease Assistance Centers, as designated by  
21 the Alzheimer's Disease Assistance Act and identified in  
22 the Department of Public Health's Alzheimer's Disease  
23 State Plan dated December 2016, shall be paid an  
24 Alzheimer's treatment access payment equal to the product  
25 of the qualifying hospital's State Fiscal Year 2018 total  
26 inpatient fee-for-service days multiplied by the

1 applicable Alzheimer's treatment rate of \$226.30 for  
2 hospitals located in Cook County and \$116.21 for hospitals  
3 located outside Cook County.

4 (d-2) Fee-for-service supplemental payments. Beginning  
5 January 1, 2023, each Illinois hospital shall receive an  
6 annual payment equal to the amounts listed below, to be paid in  
7 12 equal installments on or before the seventh State business  
8 day of each month, except that no payment shall be due within  
9 30 days after the later of the date of notification of federal  
10 approval of the payment methodologies required under this  
11 Section or any waiver required under 42 CFR 433.68, at which  
12 time the sum of amounts required under this Section prior to  
13 the date of notification is due and payable. The Department  
14 may adjust the rates in paragraphs (1) through (7) to comply  
15 with the federal upper payment limits, with such adjustments  
16 being determined so that the total estimated spending by  
17 hospital class, under such adjusted rates, remains  
18 substantially similar to the total estimated spending under  
19 the original rates set forth in this subsection.

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

26 (2) For safety-net hospitals, as described in

1 subsection (f), \$1,350 per inpatient day contained in paid  
2 fee-for-service claims and \$1,350 per paid fee-for-service  
3 outpatient claim for dates of service in Calendar Year  
4 2019 in the Department's Enterprise Data Warehouse as of  
5 August 6, 2021.

6 (3) For long term acute care hospitals, \$550 per  
7 covered inpatient day contained in paid fee-for-service  
8 claims for dates of service in Calendar Year 2019 in the  
9 Department's Enterprise Data Warehouse as of August 6,  
10 2021.

11 (4) For freestanding psychiatric hospitals, \$200 per  
12 covered inpatient day contained in paid fee-for-service  
13 claims and \$200 per paid fee-for-service outpatient claim  
14 for dates of service in Calendar Year 2019 in the  
15 Department's Enterprise Data Warehouse as of August 6,  
16 2021.

17 (5) For freestanding rehabilitation hospitals, \$550  
18 per covered inpatient day contained in paid  
19 fee-for-service claims and \$125 per paid fee-for-service  
20 outpatient claim for dates of service in Calendar Year  
21 2019 in the Department's Enterprise Data Warehouse as of  
22 August 6, 2021.

23 (6) For all general acute care hospitals and high  
24 Medicaid hospitals as defined in subsection (f), \$500 per  
25 covered inpatient day for dates of service in Calendar  
26 Year 2019 contained in paid fee-for-service claims and

1           \$500 per paid fee-for-service outpatient claim in the  
2           Department's Enterprise Data Warehouse as of August 6,  
3           2021.

4           (7) For public hospitals, as defined in subsection  
5           (f), \$275 per covered inpatient day contained in paid  
6           fee-for-service claims and \$275 per paid fee-for-service  
7           outpatient claim for dates of service in Calendar Year  
8           2019 in the Department's Enterprise Data Warehouse as of  
9           August 6, 2021.

10          (8) Alzheimer's treatment access payment. Each  
11          Illinois academic medical center or teaching hospital, as  
12          defined in Section 5-5e.2 of this Code, that is identified  
13          as the primary hospital affiliate of one of the Regional  
14          Alzheimer's Disease Assistance Centers, as designated by  
15          the Alzheimer's Disease Assistance Act and identified in  
16          the Department of Public Health's Alzheimer's Disease  
17          State Plan dated December 2016, shall be paid an  
18          Alzheimer's treatment access payment equal to the product  
19          of the qualifying hospital's Calendar Year 2019 total  
20          inpatient fee-for-service days, in the Department's  
21          Enterprise Data Warehouse as of August 6, 2021, multiplied  
22          by the applicable Alzheimer's treatment rate of \$244.37  
23          for hospitals located in Cook County and \$312.03 for  
24          hospitals located outside Cook County.

25          (e) The Department shall require managed care  
26          organizations (MCOs) to make directed payments and

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

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

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

22 (A) Beginning July 1, 2020 through December 31, 2022,  
23 critical access hospitals. Beginning January 1, 2023,  
24 "critical access hospital" means a hospital designated by  
25 the Department of Public Health as a critical access  
26 hospital, excluding any hospital meeting the definition of

1 a public hospital in subparagraph (F).

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

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

24 (ii) If a hospital elects assignment in the high  
25 Medicaid hospital class as defined in subparagraph  
26 (G), the hospital must remain in the high Medicaid

1           hospital class for the entire calendar year.

2           (C) Long term acute care hospitals.

3           (D) Freestanding psychiatric hospitals.

4           (E) Freestanding rehabilitation hospitals.

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

10          (G) High Medicaid hospitals.

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

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

1 threshold, the State fiscal year ending 18 months  
2 prior to the beginning of the calendar year. For  
3 purposes of calculating MIUR under this Section,  
4 children's hospitals and affiliated general acute  
5 care hospitals shall be considered a single  
6 hospital.

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

1 visits, the Department shall use dates of service  
2 provided during State Fiscal Year 2020 for the  
3 Payout Quarter beginning January 1, 2023. The  
4 Department shall use dates of service from the  
5 State fiscal year ending 18 month before the  
6 beginning of the first Payout Quarter of the  
7 subsequent annual determination period.

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

16 (H) General acute care hospitals. As used under this  
17 Section, "general acute care hospitals" means all other  
18 Illinois hospitals not identified in subparagraphs (A)  
19 through (G).

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

25 (3) Beginning January 1, 2024, the Department may reassign  
26 hospitals or entire hospital classes as defined above, if

1 federal limits on the payments to the class to which the  
2 hospitals are assigned based on the criteria in this  
3 subsection prevent the Department from making payments to the  
4 class that would otherwise be due under this Section. The  
5 Department shall publish the criteria and composition of each  
6 new class based on the reassignments, and the projected impact  
7 on payments to each hospital under the new classes on its  
8 website by November 15 of the year before the year in which the  
9 class changes become effective.

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

22 (1) Inpatient per unit add-on. A quarterly uniform per  
23 diem add-on shall be derived by dividing the quarterly  
24 Inpatient Directed Payments Pool amount allocated to the  
25 applicable hospital class by the total inpatient days  
26 contained on all encounter claims received during the

1 Determination Quarter, for all hospitals in the class.

2 (A) Each hospital in the class shall have a  
3 quarterly inpatient directed payment calculated that  
4 is equal to the product of the number of inpatient days  
5 attributable to the hospital used in the calculation  
6 of the quarterly uniform class per diem add-on,  
7 multiplied by the calculated applicable quarterly  
8 uniform class per diem add-on of the hospital class.

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

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

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

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

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

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

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

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

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

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

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

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

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

26          (6) For the period January 1, 2023 through December

1           31, 2023, the Department shall establish the amounts that  
2           shall be allocated to the hospital class directed payment  
3           fixed pools identified in this paragraph for the quarterly  
4           development of a uniform per unit add-on. The Department  
5           shall establish such amounts so that the total amount of  
6           payments to each hospital under this Section in calendar  
7           year 2023 is projected to be substantially similar to the  
8           total amount of such payments received by the hospital  
9           under this Section in calendar year 2021, adjusted for  
10          increased funding provided for fixed pool directed  
11          payments under subsection (g) in calendar year 2022,  
12          assuming that the volume and acuity of claims are held  
13          constant. The Department shall publish the directed  
14          payment fixed pool amounts to be established under this  
15          paragraph on its website by November 15, 2022.

16                   (A) Hospital inpatient services for critical  
17                   access hospitals.

18                   (B) Hospital outpatient services for critical  
19                   access hospitals.

20                   (C) Hospital inpatient services for public  
21                   hospitals.

22                   (D) Hospital outpatient services for public  
23                   hospitals.

24                   (E) Hospital inpatient services for safety-net  
25                   hospitals.

26                   (F) Hospital outpatient services for safety-net

1 hospitals.

2 (7) Semi-annual rate maintenance review. The  
3 Department shall ensure that hospitals assigned to the  
4 fixed pools in paragraph (6) are paid no less than 95% of  
5 the annual initial rate for each 6-month period of each  
6 annual payout period. For each calendar year, the  
7 Department shall calculate the annual initial rate per day  
8 and per visit for each fixed pool hospital class listed in  
9 paragraph (6), by dividing the total of all applicable  
10 inpatient or outpatient directed payments issued in the  
11 preceding calendar year to the hospitals in each fixed  
12 pool class for the calendar year, plus any increase  
13 resulting from the annual adjustments described in  
14 subsection (i), by the actual applicable total service  
15 units for the preceding calendar year which were the basis  
16 of the total applicable inpatient or outpatient directed  
17 payments issued to the hospitals in each fixed pool class  
18 in the calendar year, except that for calendar year 2023,  
19 the service units from calendar year 2021 shall be used.

20 (A) The Department shall calculate the effective  
21 rate, per day and per visit, for the payout periods of  
22 January to June and July to December of each year, for  
23 each fixed pool listed in paragraph (6), by dividing  
24 50% of the annual pool by the total applicable  
25 reported service units for the 2 applicable  
26 determination quarters.

1           (B) If the effective rate calculated in  
2           subparagraph (A) is less than 95% of the annual  
3           initial rate assigned to the class for each pool under  
4           paragraph (6), the Department shall adjust the payment  
5           for each hospital to a level equal to no less than 95%  
6           of the annual initial rate, by issuing a retroactive  
7           adjustment payment for the 6-month period under review  
8           as identified in subparagraph (A).

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

21               (1) For general acute care hospitals an amount equal  
22               to \$1,750 multiplied by the hospital's category of service  
23               20 case mix index for the determination quarter multiplied  
24               by the hospital's total number of inpatient admissions for  
25               category of service 20 for the determination quarter.

26               (2) For general acute care hospitals an amount equal

1 to \$160 multiplied by the hospital's category of service  
2 21 case mix index for the determination quarter multiplied  
3 by the hospital's total number of inpatient admissions for  
4 category of service 21 for the determination quarter.

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

10 (4) For general acute care hospitals an amount equal  
11 to \$375 multiplied by the hospital's category of service  
12 24 case mix index for the determination quarter multiplied  
13 by the hospital's total number of category of service 24  
14 paid EAPG (EAPGs) for the determination quarter.

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

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

26 (7) For high Medicaid hospitals an amount equal to

1           \$1,800 multiplied by the hospital's category of service 20  
2           case mix index for the determination quarter multiplied by  
3           the hospital's total number of inpatient admissions for  
4           category of service 20 for the determination quarter.

5           (8) For high Medicaid hospitals an amount equal to  
6           \$160 multiplied by the hospital's category of service 21  
7           case mix index for the determination quarter multiplied by  
8           the hospital's total number of inpatient admissions for  
9           category of service 21 for the determination quarter.

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

15          (10) For high Medicaid hospitals an amount equal to  
16          \$400 multiplied by the hospital's category of service 24  
17          case mix index for the determination quarter multiplied by  
18          the hospital's total number of category of service 24 paid  
19          EAPG outpatient claims for the determination quarter.

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

26          (12) For high Medicaid hospitals an amount equal to

1           \$290 multiplied by the hospital's category of service 29  
2           case mix index for the determination quarter multiplied by  
3           the hospital's total number of category of service 29 paid  
4           EAPGs for the determination quarter.

5           (13) For long term acute care hospitals the amount of  
6           \$495 multiplied by the hospital's total number of  
7           inpatient days for the determination quarter.

8           (14) For psychiatric hospitals the amount of \$210  
9           multiplied by the hospital's total number of inpatient  
10          days for category of service 21 for the determination  
11          quarter.

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

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

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

24          (18) Effective for the Payout Quarter beginning  
25          January 1, 2023, for the directed payments to hospitals  
26          required under this subsection, the Department shall

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

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

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

1           its quarterly determination report.

2           Notwithstanding any other provision of this subsection, if  
3           the Department determines that the actual total hospital  
4           utilization data that is used to calculate the fixed rate  
5           directed payments is substantially different than anticipated  
6           when the rates in this subsection were initially determined  
7           for unforeseeable circumstances (such as the COVID-19 pandemic  
8           or some other public health emergency), the Department may  
9           adjust the rates specified in this subsection so that the  
10          total directed payments approximate the total spending amount  
11          anticipated when the rates were initially established.

12          Definitions. As used in this subsection:

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

15                   (B) "Determination Quarter" means each calendar  
16                   quarter which ends 3 months prior to the first day of  
17                   each Payout Quarter.

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

1           each quarter by summing the relative weight of all  
2           paid EAPGs in the applicable Determination Quarter and  
3           dividing the sum by the sum total of paid EAPGs for the  
4           associated claims.

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

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

23           (2) Beginning January 1, 2024, the fixed rates for the  
24          directed payments referenced in paragraph (18) of  
25          subsection (h) for each hospital class shall be uniformly  
26          increased by a ratio of not less than, the ratio of the

1 total pass-through reduction amount pursuant to paragraph  
2 (4) of subsection (j), for the hospitals comprising the  
3 hospital directed payment class for the next calendar  
4 year, to the total inpatient and outpatient directed  
5 payments for the hospitals comprising the hospital fixed  
6 rate directed payment class paid during the preceding  
7 calendar year.

8 (j) Pass-through payments.

9 (1) For the period July 1, 2020 through December 31,  
10 2020, the Department shall assign quarterly pass-through  
11 payments to each class of hospitals equal to one-fourth of  
12 the following annual allocations:

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

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

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

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

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

18 (F) \$40,825,444 to freestanding psychiatric  
19 hospitals.

20 (G) \$9,652,108 to freestanding rehabilitation  
21 hospitals.

22 (2) For the period of July 1, 2020 through December  
23 31, 2020, the pass-through payments shall at a minimum  
24 ensure hospitals receive a total amount of monthly  
25 payments under this Section as received in calendar year  
26 2019 in accordance with this Article and paragraph (1) of

1 subsection (d-5) of Section 14-12, exclusive of amounts  
2 received through payments referenced in subsection (b).

3 (3) For the calendar year beginning January 1, 2023,  
4 the Department shall establish the annual pass-through  
5 allocation to each class of hospitals and the pass-through  
6 payments to each hospital 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 pass-through  
15 allocation to each class and the pass-through payments to  
16 each hospital to be established under this subsection on  
17 its website by November 15, 2022.

18 (4) For the calendar years beginning January 1, 2021  
19 and January 1, 2022, each hospital's pass-through payment  
20 amount shall be reduced proportionally to the reduction of  
21 all pass-through payments required by federal regulations.  
22 Beginning January 1, 2024, the Department shall reduce  
23 total pass-through payments by the minimum amount  
24 necessary to comply with federal regulations. Pass-through  
25 payments to safety-net hospitals, as defined in Section  
26 5-5e.1 of this Code, shall not be reduced until all

1 pass-through payments to other hospitals have been  
2 eliminated. All other hospitals shall have their  
3 pass-through payments reduced proportionally.

4 (k) At least 30 days prior to each calendar year, the  
5 Department shall notify each hospital of changes to the  
6 payment methodologies in this Section, including, but not  
7 limited to, changes in the fixed rate directed payment rates,  
8 the aggregate pass-through payment amount for all hospitals,  
9 and the hospital's pass-through payment amount for the  
10 upcoming calendar year.

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

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

24 (n) In order to address the escalating infant mortality  
25 rates among minority communities in Illinois, the State shall,  
26 subject to appropriation, create a pool of funding of at least

1 \$50,000,000 annually to be disbursed among safety-net  
2 hospitals that maintain perinatal designation from the  
3 Department of Public Health. The funding shall be used to  
4 preserve or enhance OB/GYN services or other specialty  
5 services at the receiving hospital, with the distribution of  
6 funding to be established by rule and with consideration to  
7 perinatal hospitals with safe birthing levels and quality  
8 metrics for healthy mothers and babies.

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

25 (p) For calendar year 2023, the final amounts, rates, and  
26 payments under subsections (c), (d-2), (g), (h), and (j) shall

1 be established by the Department, so that the sum of the total  
2 estimated annual payments under subsections (c), (d-2), (g),  
3 (h), and (j) for each hospital class for calendar year 2023, is  
4 no less than:

5 (1) \$858,260,000 to safety-net hospitals.

6 (2) \$86,200,000 to critical access hospitals.

7 (3) \$1,765,000,000 to high Medicaid hospitals.

8 (4) \$673,860,000 to general acute care hospitals.

9 (5) \$48,330,000 to long term acute care hospitals.

10 (6) \$89,110,000 to freestanding psychiatric hospitals.

11 (7) \$24,300,000 to freestanding rehabilitation  
12 hospitals.

13 (8) \$32,570,000 to public hospitals.

14 (q) Hospital Pandemic Recovery Stabilization Payments. The  
15 Department shall disburse a pool of \$460,000,000 in stability  
16 payments to hospitals prior to April 1, 2023. The allocation  
17 of the pool shall be based on the hospital directed payment  
18 classes and directed payments issued, during Calendar Year  
19 2022 with added consideration to safety net hospitals, as  
20 defined in subdivision (f)(1)(B) of this Section, and critical  
21 access hospitals.

22 (r) Directed payment update. For calendar year 2025, and  
23 each calendar year thereafter, the final amounts, rates, and  
24 payments for the fixed pool directed payments described in  
25 subsection (g) and the fixed rate directed payments described  
26 in subsection (h) shall be established by the Department at no

1 less than the following:

2 (1) \$579,261,585 for inpatient services at safety-net  
3 hospitals.

4 (2) \$763,418,138 for outpatient services at safety-net  
5 hospitals.

6 (3) \$12,389,160 for inpatient services at critical  
7 access hospitals.

8 (4) \$137,437,866 for outpatient services at critical  
9 access hospitals.

10 (5) \$5,418 as a base fixed rate per admit prior to  
11 adjusting for acuity, for inpatient services at high  
12 Medicaid hospitals.

13 (6) \$1,512 as a base fixed rate per paid E-APG prior to  
14 adjusting for acuity, for outpatient services at high  
15 Medicaid hospitals.

16 (7) \$3,898 as a base fixed rate per admit prior to  
17 adjusting for acuity, for inpatient services at other  
18 acute care hospitals.

19 (8) \$1,322 as a base fixed rate per E-APG prior to  
20 adjusting for acuity, for outpatient services at other  
21 acute hospitals.

22 (9) \$773 per day for inpatient services at long term  
23 acute care hospitals.

24 (10) \$206 per day for inpatient services at  
25 freestanding psychiatric hospitals.

26 (11) \$223 per claim for outpatient services at

1 freestanding psychiatric hospitals.

2 (12) \$776 per day for inpatient services at  
3 freestanding rehabilitation hospitals.

4 (13) \$252 per claim for outpatient services at  
5 freestanding rehabilitation hospitals.

6 (14) \$7,793,812 for inpatient services at public  
7 hospitals.

8 (15) \$26,849,592 for outpatient services at public  
9 hospitals.

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

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

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

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

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

22 (305 ILCS 5/5A-14)

23 Sec. 5A-14. Repeal of assessments and disbursements.

24 (a) (Blank). ~~Section 5A-2 is repealed on December 31,~~  
25 ~~2026.~~

1 (b) Section 5A-12 is repealed on July 1, 2005.

2 (c) Section 5A-12.1 is repealed on July 1, 2008.

3 (d) Section 5A-12.2 and Section 5A-12.4 are repealed on  
4 July 1, 2018, subject to Section 5A-16.

5 (e) Section 5A-12.3 is repealed on July 1, 2011.

6 (f) Section 5A-12.6 is repealed on July 1, 2020.

7 (g) (Blank). ~~Section 5A-12.7 is repealed on December 31,~~  
8 ~~2026.~~

9 (Source: P.A. 101-650, eff. 7-7-20; 102-886, eff. 5-17-22.)

10 (305 ILCS 5/12-4.105)

11 Sec. 12-4.105. Human poison control center; payment  
12 program. Subject to funding availability resulting from  
13 transfers made from the Hospital Provider Fund to the  
14 Healthcare Provider Relief Fund as authorized under this Code,  
15 for State fiscal year 2017 and State fiscal year 2018, and for  
16 each State fiscal year thereafter in which the assessment  
17 under Section 5A-2 is imposed, the Department of Healthcare  
18 and Family Services shall pay to the human poison control  
19 center designated under the Poison Control System Act an  
20 amount of not less than \$3,000,000 for each of State fiscal  
21 years 2017 through 2020, and for State fiscal years 2021  
22 through 2023 an amount of not less than \$3,750,000 and for  
23 State fiscal year ~~years~~ 2024 ~~through 2026~~ an amount of not less  
24 than \$4,000,000, and for State fiscal year 2025 an amount not  
25 less than \$4,500,000, and for State fiscal year 2026, and each

1 fiscal year thereafter, an amount of not less than \$4,750,000  
2 ~~and for the period July 1, 2026 through December 31, 2026 an~~  
3 ~~amount of not less than \$2,000,000, if the human poison~~  
4 control center is in operation.

5 (Source: P.A. 102-886, eff. 5-17-22; 103-102, eff. 6-16-23.)

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