AN ACT concerning health.

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

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

(5 ILCS 100/5-45.65 new)

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

This Section is repealed one year after the effective date of this amendatory Act of the 104th General Assembly.

Section 10. The Illinois Public Aid Code is amended by

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

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

(Section scheduled to be repealed on December 31, 2026)

Sec. 5A-2. Assessment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the amount calculated under this subparagraph

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

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

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

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

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

The Department shall notify hospitals of any additional

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

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

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

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

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

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

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

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

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

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

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

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

(c) (Blank).

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

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

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

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

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

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

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

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

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

(1) The name of the hospital provider.

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

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

(4) (Blank).

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

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

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

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

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

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

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

hospitals subject to the annual assessment under this paragraph.

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

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

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

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

(h) (Blank).

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

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

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

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

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

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

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

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

shall pay the Illinois Department the amount of any assessment, assessment penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. The Illinois Department may, in its discretion, foreclose on such a lien, but shall do so in a manner that is consistent with Section 5e of the Retailers' Occupation Tax Act. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalties, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Illinois Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Illinois Department showing that no assessment, penalty, or interest is due from the seller or transferor under this Article.

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

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

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

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

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

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

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

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

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

Sec. 5A-8. Hospital Provider Fund.

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

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

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

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

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

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

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

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

moneys to be deposited into the Fund.

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

General Revenue Fund ..... $80,000,000.

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

(7.1) (Blank).

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

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

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

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

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

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

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

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

(7.11) (Blank).

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

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

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

date of Public Act 98-651).

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

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

Health and Human Services Medicaid Trust Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

Healthcare Provider Relief Fund.... $325,000,000.

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

(7.15) For making transfers not exceeding the following amounts, related to State fiscal years 2023 through <u>2024</u> ~~2026~~, to the following designated funds:

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

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

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

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

Health and Human Services Medicaid Trust Fund $20,000,000
Long-Term Care Provider Fund $30,000,000
Healthcare Provider Relief Fund.... $505,637,082; however the amount shall remain $365,000,000 until the reimbursement rates described in subsection (r) of Section 5A-12.7 are fully implemented. If for any reason the assessment imposed by subsection (a) or (b-5) of Section 5A-2 is reduced, the amount of $505,637,082 shall be reduced by the same percentage.

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

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

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

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

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

(c) The Fund shall consist of the following:

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

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

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

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

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

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

(d) (Blank).

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

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

Sec. 5A-10. Applicability.

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

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

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

effect January 1, 2008 except for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-12.7)

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

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

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

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

(c) Graduate medical education.

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

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

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

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

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

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

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

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

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

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

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

(4) For freestanding psychiatric hospitals, $125 per

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a public hospital in subparagraph (F).

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

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

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

hospital class for the entire calendar year.

(C) Long term acute care hospitals.

(D) Freestanding psychiatric hospitals.

(E) Freestanding rehabilitation hospitals.

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

(G) High Medicaid hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

Determination Quarter, for all hospitals in the class.

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

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

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

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

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

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

(4) Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

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

(A) Hospital inpatient services for critical access hospitals.

(B) Hospital outpatient services for critical access hospitals.

(C) Hospital inpatient services for public hospitals.

(D) Hospital outpatient services for public hospitals.

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

(F) Hospital outpatient services for safety-net

hospitals.

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

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

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

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

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

(2) For general acute care hospitals an amount equal

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

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

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

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

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

(7) For high Medicaid hospitals an amount equal to

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

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

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

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

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

(12) For high Medicaid hospitals an amount equal to

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

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

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

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

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

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

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

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

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

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

its quarterly determination report.

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

Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

(j) Pass-through payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

less than the following:

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

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

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

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

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

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

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

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

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

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

(11) $223 per claim for outpatient services at

freestanding psychiatric hospitals.

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-14)

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

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

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

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

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

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

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

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

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

(305 ILCS 5/12-4.105)

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

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

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

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