



Sen. Omar Aquino

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10400HB2771sam002

LRB104 08638 KTG 26961 a

1 AMENDMENT TO HOUSE BILL 2771

2 AMENDMENT NO. _____. Amend House Bill 2771, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

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

7 (5 ILCS 100/5-45.65 new)

8 Sec. 5-45.65. Emergency rulemaking; Medicaid reimbursement
9 rates for hospital inpatient and outpatient services. To
10 provide for the expeditious and timely implementation of the
11 changes made by this amendatory Act of the 104th General
12 Assembly to Sections 5A-2, 5A-7, 5A-8, 5A-10, and 5A-12.7 of
13 the Illinois Public Aid Code, emergency rules implementing the
14 changes made by this amendatory Act of the 104th General
15 Assembly to Sections 5A-2, 5A-7, 5A-8, 5A-10, and 5A-12.7 of
16 the Illinois Public Aid Code may be adopted in accordance with

1 Section 5-45 by the Department of Healthcare and Family
2 Services. The adoption of emergency rules authorized by
3 Section 5-45 and this Section is deemed necessary for the
4 public interest, safety, and welfare.

5 This Section is repealed one year after the effective date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

7 Section 10. The Illinois Public Aid Code is amended by
8 changing Sections 5A-2, 5A-5, 5A-7, 5A-8, 5A-10, 5A-12.7,
9 5A-14, and 12-4.105 as follows:

10 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

11 (Section scheduled to be repealed on December 31, 2026)

12 Sec. 5A-2. Assessment.

13 (a)(1) Subject to Sections 5A-3 and 5A-10, for State
14 fiscal years 2009 through 2018, or as long as continued under
15 Section 5A-16, an annual assessment on inpatient services is
16 imposed on each hospital provider in an amount equal to
17 \$218.38 multiplied by the difference of the hospital's
18 occupied bed days less the hospital's Medicare bed days,
19 provided, however, that the amount of \$218.38 shall be
20 increased by a uniform percentage to generate an amount equal
21 to 75% of the State share of the payments authorized under
22 Section 5A-12.5, with such increase only taking effect upon
23 the date that a State share for such payments is required under
24 federal law. For the period of April through June 2015, the

1 amount of \$218.38 used to calculate the assessment under this
2 paragraph shall, by emergency rule under subsection (s) of
3 Section 5-45 of the Illinois Administrative Procedure Act, be
4 increased by a uniform percentage to generate \$20,250,000 in
5 the aggregate for that period from all hospitals subject to
6 the annual assessment under this paragraph.

7 (2) In addition to any other assessments imposed under
8 this Article, effective July 1, 2016 and semi-annually
9 thereafter through June 2018, or as provided in Section 5A-16,
10 in addition to any federally required State share as
11 authorized under paragraph (1), the amount of \$218.38 shall be
12 increased by a uniform percentage to generate an amount equal
13 to 75% of the ACA Assessment Adjustment, as defined in
14 subsection (b-6) of this Section.

15 For State fiscal years 2009 through 2018, or as provided
16 in Section 5A-16, a hospital's occupied bed days and Medicare
17 bed days shall be determined using the most recent data
18 available from each hospital's 2005 Medicare cost report as
19 contained in the Healthcare Cost Report Information System
20 file, for the quarter ending on December 31, 2006, without
21 regard to any subsequent adjustments or changes to such data.
22 If a hospital's 2005 Medicare cost report is not contained in
23 the Healthcare Cost Report Information System, then the
24 Illinois Department may obtain the hospital provider's
25 occupied bed days and Medicare bed days from any source
26 available, including, but not limited to, records maintained

1 by the hospital provider, which may be inspected at all times
2 during business hours of the day by the Illinois Department or
3 its duly authorized agents and employees.

4 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
5 fiscal years 2019 and 2020, an annual assessment on inpatient
6 services is imposed on each hospital provider in an amount
7 equal to \$197.19 multiplied by the difference of the
8 hospital's occupied bed days less the hospital's Medicare bed
9 days. For State fiscal years 2019 and 2020, a hospital's
10 occupied bed days and Medicare bed days shall be determined
11 using the most recent data available from each hospital's 2015
12 Medicare cost report as contained in the Healthcare Cost
13 Report Information System file, for the quarter ending on
14 March 31, 2017, without regard to any subsequent adjustments
15 or changes to such data. If a hospital's 2015 Medicare cost
16 report is not contained in the Healthcare Cost Report
17 Information System, then the Illinois Department may obtain
18 the hospital provider's occupied bed days and Medicare bed
19 days from any source available, including, but not limited to,
20 records maintained by the hospital provider, which may be
21 inspected at all times during business hours of the day by the
22 Illinois Department or its duly authorized agents and
23 employees. Notwithstanding any other provision in this
24 Article, for a hospital provider that did not have a 2015
25 Medicare cost report, but paid an assessment in State fiscal
26 year 2018 on the basis of hypothetical data, that assessment

1 amount shall be used for State fiscal years 2019 and 2020.

2 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
3 (b-8), for the period of July 1, 2020 through December 31, 2020
4 and calendar years 2021 through 2024 ~~2026~~, an annual
5 assessment on inpatient services is imposed on each hospital
6 provider in an amount equal to \$221.50 multiplied by the
7 difference of the hospital's occupied bed days less the
8 hospital's Medicare bed days, provided however: for the period
9 of July 1, 2020 through December 31, 2020, (i) the assessment
10 shall be equal to 50% of the annual amount; and (ii) the amount
11 of \$221.50 shall be retroactively adjusted by a uniform
12 percentage to generate an amount equal to 50% of the
13 Assessment Adjustment, as defined in subsection (b-7). For the
14 period of July 1, 2020 through December 31, 2020 and calendar
15 years 2021 through 2024 ~~2026~~, a hospital's occupied bed days
16 and Medicare bed days shall be determined using the most
17 recent data available from each hospital's 2015 Medicare cost
18 report as contained in the Healthcare Cost Report Information
19 System file, for the quarter ending on March 31, 2017, without
20 regard to any subsequent adjustments or changes to such data.
21 If a hospital's 2015 Medicare cost report is not contained in
22 the Healthcare Cost Report Information System, then the
23 Illinois Department may obtain the hospital provider's
24 occupied bed days and Medicare bed days from any source
25 available, including, but not limited to, records maintained
26 by the hospital provider, which may be inspected at all times

1 during business hours of the day by the Illinois Department or
2 its duly authorized agents and employees. Should the change in
3 the assessment methodology for fiscal years 2021 through
4 December 31, 2022 not be approved on or before June 30, 2020,
5 the assessment and payments under this Article in effect for
6 fiscal year 2020 shall remain in place until the new
7 assessment is approved. If the assessment methodology for July
8 1, 2020 through December 31, 2022, is approved on or after July
9 1, 2020, it shall be retroactive to July 1, 2020, subject to
10 federal approval and provided that the payments authorized
11 under Section 5A-12.7 have the same effective date as the new
12 assessment methodology. In giving retroactive effect to the
13 assessment approved after June 30, 2020, credit toward the new
14 assessment shall be given for any payments of the previous
15 assessment for periods after June 30, 2020. Notwithstanding
16 any other provision of this Article, for a hospital provider
17 that did not have a 2015 Medicare cost report, but paid an
18 assessment in State Fiscal Year 2020 on the basis of
19 hypothetical data, the data that was the basis for the 2020
20 assessment shall be used to calculate the assessment under
21 this paragraph until December 31, 2023. Beginning July 1, 2022
22 and through December 31, 2024, a safety-net hospital that had
23 a change of ownership in calendar year 2021, and whose
24 inpatient utilization had decreased by 90% from the prior year
25 and prior to the change of ownership, may be eligible to pay a
26 tax based on hypothetical data based on a determination of

1 financial distress by the Department. Subject to federal
2 approval, the Department may, by January 1, 2024, develop a
3 hypothetical tax for a specialty cancer hospital which had a
4 structural change of ownership during calendar year 2022 from
5 a for-profit entity to a non-profit entity, and which has
6 experienced a decline of 60% or greater in inpatient days of
7 care as compared to the prior owners 2015 Medicare cost
8 report. This change of ownership may make the hospital
9 eligible for a hypothetical tax under the new hospital
10 provision of the assessment defined in this Section. This new
11 hypothetical tax may be applicable from January 1, 2024
12 through December 31, 2026.

13 (5) Subject to Sections 5A-3 and 5A-10, beginning January
14 1, 2025, an annual assessment on inpatient services is imposed
15 on each hospital provider in an amount equal to \$362, or any
16 reduction thereof in accordance with this subsection,
17 multiplied by the difference of the hospital's occupied bed
18 days less the hospital's Medicare bed days; however, the rate
19 shall be \$221.50 until the Department receives federal
20 approval and implements the reimbursement rates in subsection
21 (r) of Section 5A-12.7. The Department may bill for the
22 difference between the assessment rate of \$362, or any
23 reduction thereof in accordance with this subsection, and
24 \$221.50 no earlier than 17 calendar days after implementing
25 the reimbursement rates in subsection (r) of Section 5A-12.7.

26 (A) Upon receiving federal approval for the

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

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

1 authorized agents and employees. If the reimbursement
2 rates in subsection (r) of Section 5A-12.7 require
3 reduction to comply with federal spending limits, then the
4 tax rate of \$362 shall be reduced, in accordance with
5 subsection (s) of Section 5A-12.7, by the same percentage
6 reduction to payments required to comply with federal
7 spending limits.

8 (b) (Blank).

9 (b-5) (1) Subject to Sections 5A-3 and 5A-10, for the
10 portion of State fiscal year 2012, beginning June 10, 2012
11 through June 30, 2012, and for State fiscal years 2013 through
12 2018, or as provided in Section 5A-16, an annual assessment on
13 outpatient services is imposed on each hospital provider in an
14 amount equal to .008766 multiplied by the hospital's
15 outpatient gross revenue, provided, however, that the amount
16 of .008766 shall be increased by a uniform percentage to
17 generate an amount equal to 25% of the State share of the
18 payments authorized under Section 5A-12.5, with such increase
19 only taking effect upon the date that a State share for such
20 payments is required under federal law. For the period
21 beginning June 10, 2012 through June 30, 2012, the annual
22 assessment on outpatient services shall be prorated by
23 multiplying the assessment amount by a fraction, the numerator
24 of which is 21 days and the denominator of which is 365 days.
25 For the period of April through June 2015, the amount of
26 .008766 used to calculate the assessment under this paragraph

1 shall, by emergency rule under subsection (s) of Section 5-45
2 of the Illinois Administrative Procedure Act, be increased by
3 a uniform percentage to generate \$6,750,000 in the aggregate
4 for that period from all hospitals subject to the annual
5 assessment under this paragraph.

6 (2) In addition to any other assessments imposed under
7 this Article, effective July 1, 2016 and semi-annually
8 thereafter through June 2018, in addition to any federally
9 required State share as authorized under paragraph (1), the
10 amount of .008766 shall be increased by a uniform percentage
11 to generate an amount equal to 25% of the ACA Assessment
12 Adjustment, as defined in subsection (b-6) of this Section.

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

1 Department or its duly authorized agents and employees.

2 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
3 fiscal years 2019 and 2020, an annual assessment on outpatient
4 services is imposed on each hospital provider in an amount
5 equal to .01358 multiplied by the hospital's outpatient gross
6 revenue. For State fiscal years 2019 and 2020, a hospital's
7 outpatient gross revenue shall be determined using the most
8 recent data available from each hospital's 2015 Medicare cost
9 report as contained in the Healthcare Cost Report Information
10 System file, for the quarter ending on March 31, 2017, without
11 regard to any subsequent adjustments or changes to such data.
12 If a hospital's 2015 Medicare cost report is not contained in
13 the Healthcare Cost Report Information System, then the
14 Department may obtain the hospital provider's outpatient gross
15 revenue from any source available, including, but not limited
16 to, records maintained by the hospital provider, which may be
17 inspected at all times during business hours of the day by the
18 Department or its duly authorized agents and employees.
19 Notwithstanding any other provision in this Article, for a
20 hospital provider that did not have a 2015 Medicare cost
21 report, but paid an assessment in State fiscal year 2018 on the
22 basis of hypothetical data, that assessment amount shall be
23 used for State fiscal years 2019 and 2020.

24 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
25 (b-8), for the period of July 1, 2020 through December 31, 2020
26 and calendar years 2021 through 2024 ~~2026~~, an annual

1 assessment on outpatient services is imposed on each hospital
2 provider in an amount equal to .01525 multiplied by the
3 hospital's outpatient gross revenue, provided however: (i) for
4 the period of July 1, 2020 through December 31, 2020, the
5 assessment shall be equal to 50% of the annual amount; and (ii)
6 the amount of .01525 shall be retroactively adjusted by a
7 uniform percentage to generate an amount equal to 50% of the
8 Assessment Adjustment, as defined in subsection (b-7). For the
9 period of July 1, 2020 through December 31, 2020 and calendar
10 years 2021 through 2024 ~~2026~~, a hospital's outpatient gross
11 revenue shall be determined using the most recent data
12 available from each hospital's 2015 Medicare cost report as
13 contained in the Healthcare Cost Report Information System
14 file, for the quarter ending on March 31, 2017, without regard
15 to any subsequent adjustments or changes to such data. If a
16 hospital's 2015 Medicare cost report is not contained in the
17 Healthcare Cost Report Information System, then the Illinois
18 Department may obtain the hospital provider's outpatient
19 revenue data from any source available, including, but not
20 limited to, records maintained by the hospital provider, which
21 may be inspected at all times during business hours of the day
22 by the Illinois Department or its duly authorized agents and
23 employees. Should the change in the assessment methodology
24 above for fiscal years 2021 through calendar year 2022 not be
25 approved prior to July 1, 2020, the assessment and payments
26 under this Article in effect for fiscal year 2020 shall remain

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

23 (5) Subject to Sections 5A-3 and 5A-10, beginning January
24 1, 2025, an annual assessment on outpatient services is
25 imposed on each hospital provider in an amount equal to
26 .03273, or any reduction thereof in accordance with this

1 subsection, multiplied by the hospital's outpatient gross
2 revenue; however the rate shall remain .01525, until the
3 Department receives federal approval and implements the
4 reimbursement rates of payment in subsection (r) of Section
5 5A-12.7. The Department may bill for the difference between
6 the assessment multiplier of .03273 and .01525 no earlier than
7 17 calendar days after the first payment based on the
8 reimbursement rates in subsection (r) of Section 5A-12.7.

9 (A) Upon receiving federal approval for the
10 reimbursement rates in subsection (r) of Section 5A-12.7,
11 the Department shall bill the hospital for the incremental
12 difference in total tax due resulting from the increase
13 provided in this subsection for the number of months from
14 January 1, 2025 through the date of federal approval. The
15 amount shall be due and payable no later than December 31,
16 2025 and no earlier than 17 calendar days after
17 implementing the reimbursement rates in subsection (r) of
18 Section 5A-12.7. The Department shall bill hospitals in
19 the same proportional rate as the Department has
20 implemented the outpatient reimbursement rates in
21 subsection (r) of Section 5A-12.7.

22 (B) Beginning January 1, 2025, a hospital's outpatient
23 gross revenue shall be determined using the most recent
24 data available from each hospital's 2015 Medicare cost
25 report as contained in the Healthcare Cost Report
26 Information System file, for the quarter ending on March

1 31, 2017, without regard to any subsequent adjustments or
2 changes to such data. If a hospital's 2015 Medicare cost
3 report is not contained in the Healthcare Cost Report
4 Information System, then the Department may obtain the
5 hospital provider's outpatient revenue data from any
6 source available, including, but not limited to, records
7 maintained by the hospital provider, which may be
8 inspected at all times during business hours of the day by
9 the Department or its duly authorized agents and
10 employees. If the reimbursement rates in subsection (r) of
11 Section 5A-12.7 require reduction to comply with federal
12 spending limits, then the tax rate of .03273 shall be
13 reduced, in accordance with subsection (s) of Section
14 5A-12.7, by the same percentage reduction to payments
15 required to comply with federal spending limits.

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

18 (A) For the period of July 1, 2016 through December
19 31, 2016, the product of .19125 multiplied by the sum of
20 the fee-for-service payments to hospitals as authorized
21 under Section 5A-12.5 and the adjustments authorized under
22 subsection (t) of Section 5A-12.2 to managed care
23 organizations for hospital services due and payable in the
24 month of April 2016 multiplied by 6.

25 (B) For the period of January 1, 2017 through June 30,
26 2017, the product of .19125 multiplied by the sum of the

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

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

1 (D) For the period of January 1, 2018 through June 30,
2 2018, the product of .19125 multiplied by the sum of the
3 fee-for-service payments to hospitals as authorized under
4 Section 5A-12.5 and the adjustments authorized under
5 subsection (t) of Section 5A-12.2 to managed care
6 organizations for hospital services due and payable in the
7 month of October 2017 multiplied by 6, except that:

8 (i) the amount calculated under this subparagraph

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

16 (ii) the amount calculated under this subparagraph

17 (D) shall be adjusted to include the product of .19125
18 multiplied by the sum of the fee-for-service payments,
19 if any, estimated to be paid to hospitals under
20 subsection (b) of Section 5A-12.5.

21 (2) The Department shall complete and apply a final
22 reconciliation of the ACA Assessment Adjustment prior to June
23 30, 2018 to account for:

24 (A) any differences between the actual payments issued
25 or scheduled to be issued prior to June 30, 2018 as
26 authorized in Section 5A-12.5 for the period of January 1,

1 2018 through June 30, 2018 and the estimated payments due
2 and payable in the month of October 2017 multiplied by 6 as
3 described in subparagraph (D); and

4 (B) any difference between the estimated
5 fee-for-service payments under subsection (b) of Section
6 5A-12.5 and the amount of such payments that are actually
7 scheduled to be paid.

8 The Department shall notify hospitals of any additional
9 amounts owed or reduction credits to be applied to the June
10 2018 ACA Assessment Adjustment. This is to be considered the
11 final reconciliation for the ACA Assessment Adjustment.

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

23 (4) The increases authorized under paragraph (2) of
24 subsection (a) and paragraph (2) of subsection (b-5) shall be
25 limited to the federally required State share of the total
26 payments authorized under Section 5A-12.5 if the sum of such

1 payments yields an annualized amount equal to or less than
2 \$450,000,000, or if the adjustments authorized under
3 subsection (t) of Section 5A-12.2 are found not to be
4 actuarially sound; however, this limitation shall not apply to
5 the fee-for-service payments described in subsection (b) of
6 Section 5A-12.5.

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

9 (A) For the period of July 1, 2020 through December
10 31, 2020, the product of .3853 multiplied by the total of
11 the actual payments made under subsections (c) through (k)
12 of Section 5A-12.7 attributable to the period, less the
13 total of the assessment imposed under subsections (a) and
14 (b-5) of this Section for the period.

15 (B) For each calendar quarter beginning January 1,
16 2021 through December 31, 2022, the product of .3853
17 multiplied by the total of the actual payments made under
18 subsections (c) through (k) of Section 5A-12.7
19 attributable to the period, less the total of the
20 assessment imposed under subsections (a) and (b-5) of this
21 Section for the period.

22 (C) Beginning on January 1, 2023, and each subsequent
23 July 1 and January 1, the product of .3853 multiplied by
24 the total of the actual payments made under subsections
25 (c) through (j) and subsection (r) of Section 5A-12.7
26 attributable to the 6-month period immediately preceding

1 the period to which the adjustment applies, less the total
2 of the assessment imposed under subsections (a) and (b-5)
3 of this Section for the 6-month period immediately
4 preceding the period to which the adjustment applies.

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

25 (3) The Department shall publish all details of the
26 Assessment Adjustment calculation performed each year on its

1 website within 30 days of completing the calculation, and also
2 submit the details of the Assessment Adjustment calculation as
3 part of the Department's annual report to the General
4 Assembly.

5 (b-8) Notwithstanding any other provision of this Article,
6 the Department shall reduce the assessments imposed on each
7 hospital under subsections (a) and (b-5) by the uniform
8 percentage necessary to reduce the total assessment imposed on
9 all hospitals by an aggregate amount of \$240,000,000, with
10 such reduction being applied by June 30, 2022. The assessment
11 reduction required for each hospital under this subsection
12 shall be forever waived, forgiven, and released by the
13 Department.

14 (c) (Blank).

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

20 (e) Notwithstanding any other provision of this Section,
21 any plan providing for an assessment on a hospital provider as
22 a permissible tax under Title XIX of the federal Social
23 Security Act and Medicaid-eligible payments to hospital
24 providers from the revenues derived from that assessment shall
25 be reviewed by the Illinois Department of Healthcare and
26 Family Services, as the Single State Medicaid Agency required

1 by federal law, to determine whether those assessments and
2 hospital provider payments meet federal Medicaid standards. If
3 the Department determines that the elements of the plan may
4 meet federal Medicaid standards and a related State Medicaid
5 Plan Amendment is prepared in a manner and form suitable for
6 submission, that State Plan Amendment shall be submitted in a
7 timely manner for review by the Centers for Medicare and
8 Medicaid Services of the United States Department of Health
9 and Human Services and subject to approval by the Centers for
10 Medicare and Medicaid Services of the United States Department
11 of Health and Human Services. No such plan shall become
12 effective without approval by the Illinois General Assembly by
13 the enactment into law of related legislation. Notwithstanding
14 any other provision of this Section, the Department is
15 authorized to adopt rules to reduce the rate of any annual
16 assessment imposed under this Section. Any such rules may be
17 adopted by the Department under Section 5-50 of the Illinois
18 Administrative Procedure Act.

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

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

1 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)

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

3 (a) The Illinois Department shall send a notice of
4 assessment to every hospital provider subject to assessment
5 under this Article. The notice of assessment shall notify the
6 hospital of its assessment and shall be sent after receipt by
7 the Department of notification from the Centers for Medicare
8 and Medicaid Services of the U.S. Department of Health and
9 Human Services that the payment methodologies required under
10 this Article and, if necessary, the waiver granted under 42
11 CFR 433.68 have been approved. The notice shall be on a form
12 prepared by the Illinois Department and shall state the
13 following:

14 (1) The name of the hospital provider.

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

20 (3) The occupied bed days, occupied bed days less
21 Medicare days, adjusted gross hospital revenue, or
22 outpatient gross revenue of the hospital provider
23 (whichever is applicable), the amount of assessment
24 imposed under Section 5A-2 for the State fiscal year for
25 which the notice is sent, and the amount of each

1 installment to be paid during the State fiscal year.

2 (4) (Blank).

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

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

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

22 (d) Notwithstanding any other provision in this Article, a
23 provider who commences conducting, operating, or maintaining a
24 hospital, upon notice by the Illinois Department, shall pay
25 the assessment computed under Section 5A-2 and subsection (e)
26 in installments on the due dates stated in the notice and on

1 the regular installment due dates for the State fiscal year
2 occurring after the due dates of the initial notice.

3 (e) Notwithstanding any other provision in this Article,
4 for State fiscal years 2009 through 2018, in the case of a
5 hospital provider that did not conduct, operate, or maintain a
6 hospital in 2005, the assessment for that State fiscal year
7 shall be computed on the basis of hypothetical occupied bed
8 days for the full calendar year as determined by the Illinois
9 Department. Notwithstanding any other provision in this
10 Article, for the portion of State fiscal year 2012 beginning
11 June 10, 2012 through June 30, 2012, and for State fiscal years
12 2013 through 2018, in the case of a hospital provider that did
13 not conduct, operate, or maintain a hospital in 2009, the
14 assessment under subsection (b-5) of Section 5A-2 for that
15 State fiscal year shall be computed on the basis of
16 hypothetical gross outpatient revenue for the full calendar
17 year as determined by the Illinois Department.

18 Notwithstanding any other provision in this Article,
19 beginning July 1, 2018 ~~through December 31, 2026~~, in the case
20 of a hospital provider that did not conduct, operate, or
21 maintain a hospital in the year that is the basis of the
22 calculation of the assessment under this Article, the
23 assessment under ~~paragraph (3) of~~ subsection (a) of Section
24 5A-2 for the State fiscal year shall be computed on the basis
25 of hypothetical occupied bed days for the full calendar year
26 as determined by the Illinois Department, except that for a

1 hospital provider that did not have a 2015 Medicare cost
2 report, but paid an assessment in State fiscal year 2018 on the
3 basis of hypothetical data, that assessment amount shall be
4 used for State fiscal years 2019 and 2020; however, for State
5 fiscal year 2020, the assessment amount shall be increased by
6 the proportion that it represents of the total annual
7 assessment that is generated from all hospitals in order to
8 generate \$6,250,000 in the aggregate for that period from all
9 hospitals subject to the annual assessment under this
10 paragraph.

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

1 generate \$6,250,000 in the aggregate for that period from all
2 hospitals subject to the annual assessment under this
3 paragraph.

4 (f) Every hospital provider subject to assessment under
5 this Article shall keep sufficient records to permit the
6 determination of adjusted gross hospital revenue for the
7 hospital's fiscal year. All such records shall be kept in the
8 English language and shall, at all times during regular
9 business hours of the day, be subject to inspection by the
10 Illinois Department or its duly authorized agents and
11 employees.

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

18 (h) (Blank).

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

20 (305 ILCS 5/5A-7) (from Ch. 23, par. 5A-7)

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

22 (a) The Illinois Department shall establish and maintain a
23 listing of all hospital providers appearing in the licensing
24 records of the Illinois Department of Public Health, which
25 shall show each provider's name and principal place of

1 business and the name and address of each hospital operated,
2 conducted, or maintained by the provider in this State. The
3 listing shall also include the monthly assessment amounts owed
4 for each hospital and any unpaid assessment liability greater
5 than 90 days delinquent. The Illinois Department shall
6 administer and enforce this Article and collect the
7 assessments and penalty assessments imposed under this Article
8 using procedures employed in its administration of this Code
9 generally. The Illinois Department, its Director, and every
10 hospital provider subject to assessment under this Article
11 shall have the following powers, duties, and rights:

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

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

1 (3) Any unpaid assessment under this Article shall
2 become a lien upon the assets of the hospital upon which it
3 was assessed. If any hospital provider, outside the usual
4 course of its business, sells or transfers the major part
5 of any one or more of (A) the real property and
6 improvements, (B) the machinery and equipment, or (C) the
7 furniture or fixtures, of any hospital that is subject to
8 the provisions of this Article, the seller or transferor
9 shall pay the Illinois Department the amount of any
10 assessment, assessment penalty, and interest (if any) due
11 from it under this Article up to the date of the sale or
12 transfer. The Illinois Department may, in its discretion,
13 foreclose on such a lien, but shall do so in a manner that
14 is consistent with Section 5e of the Retailers' Occupation
15 Tax Act. If the seller or transferor fails to pay any
16 assessment, assessment penalty, and interest (if any) due,
17 the purchaser or transferee of such asset shall be liable
18 for the amount of the assessment, penalties, and interest
19 (if any) up to the amount of the reasonable value of the
20 property acquired by the purchaser or transferee. The
21 purchaser or transferee shall continue to be liable until
22 the purchaser or transferee pays the full amount of the
23 assessment, penalties, and interest (if any) up to the
24 amount of the reasonable value of the property acquired by
25 the purchaser or transferee or until the purchaser or
26 transferee receives from the Illinois Department a

1 certificate showing that such assessment, penalty, and
2 interest have been paid or a certificate from the Illinois
3 Department showing that no assessment, penalty, or
4 interest is due from the seller or transferor under this
5 Article.

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

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

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

24 (2) The requirements of this subsection may be waived
25 by the Illinois Department in instances when a hospital
26 has entered into and remains in compliance with a

1 repayment plan or a tax deferral plan. A repayment plan or
2 tax deferral plan must be entered into no later than 30
3 days after notice of an unpaid assessment payment. No
4 repayment plan may exceed a period of 36 months. No tax
5 deferral plan may exceed a period of 6 months, and
6 repayment after the end of a tax deferral plan shall not
7 exceed 36 months. Failure to remain in compliance with a
8 repayment plan or tax deferral plan shall cause immediate
9 termination of such plan unless there is prior written
10 consent from the Illinois Department for a period of
11 non-compliance.

12 (3) Beginning September 1, 2025, the Illinois
13 Department shall immediately collect all overdue unpaid
14 assessments and penalties through the collection methods
15 authorized under this Section, unless a repayment plan or
16 tax deferral plan has already been agreed to by September
17 1, 2025.

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

25 (Source: P.A. 93-659, eff. 2-3-04; 93-841, eff. 7-30-04;
26 94-242, eff. 7-18-05.)

1 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

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

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

7 (b) The Fund is created for the purpose of receiving
8 moneys in accordance with Section 5A-6 and disbursing moneys
9 only for the following purposes, notwithstanding any other
10 provision of law:

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

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

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

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

4 (5) For making transfers, as those transfers are
 5 authorized in the proceedings authorizing debt under the
 6 Short Term Borrowing Act, but transfers made under this
 7 paragraph (5) shall not exceed the principal amount of
 8 debt issued in anticipation of the receipt by the State of
 9 moneys to be deposited into the Fund.

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

16 (6.5) For making transfers to the Healthcare Provider
 17 Relief Fund, except that transfers made under this
 18 paragraph (6.5) shall not exceed \$60,000,000 in the
 19 aggregate.

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

23	Health and Human Services Medicaid Trust	
24	Fund	\$20,000,000
25	Long-Term Care Provider Fund	\$30,000,000
26	General Revenue Fund	\$80,000,000.

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

5 (7.1) (Blank).

6 (7.5) (Blank).

7 (7.8) (Blank).

8 (7.9) (Blank).

9 (7.10) For State fiscal year 2014, for making
10 transfers of the moneys resulting from the assessment
11 under subsection (b-5) of Section 5A-2 and received from
12 hospital providers under Section 5A-4 and transferred into
13 the Hospital Provider Fund under Section 5A-6 to the
14 designated funds not exceeding the following amounts in
15 that State fiscal year:

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

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

21 The additional amount of transfers in this paragraph
22 (7.10), authorized by Public Act 98-651, shall be made
23 within 10 State business days after June 16, 2014 (the
24 effective date of Public Act 98-651). That authority shall
25 remain in effect even if Public Act 98-651 does not become
26 law until State fiscal year 2015.

1 (7.10a) For State fiscal years 2015 through 2018, for
2 making transfers of the moneys resulting from the
3 assessment under subsection (b-5) of Section 5A-2 and
4 received from hospital providers under Section 5A-4 and
5 transferred into the Hospital Provider Fund under Section
6 5A-6 to the designated funds not exceeding the following
7 amounts related to each State fiscal year:

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

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

13 (7.11) (Blank).

14 (7.12) For State fiscal year 2013, for increasing by
15 21/365ths the transfer of the moneys resulting from the
16 assessment under subsection (b-5) of Section 5A-2 and
17 received from hospital providers under Section 5A-4 for
18 the portion of State fiscal year 2012 beginning June 10,
19 2012 through June 30, 2012 and transferred into the
20 Hospital Provider Fund under Section 5A-6 to the
21 designated funds not exceeding the following amounts in
22 that State fiscal year:

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

24 Since the federal Centers for Medicare and Medicaid
25 Services approval of the assessment authorized under
26 subsection (b-5) of Section 5A-2, received from hospital

1 providers under Section 5A-4 and the payment methodologies
 2 to hospitals required under Section 5A-12.4 was not
 3 received by the Department until State fiscal year 2014
 4 and since the Department made retroactive payments during
 5 State fiscal year 2014 related to the referenced period of
 6 June 2012, the transfer authority granted in this
 7 paragraph (7.12) is extended through the date that is 10
 8 State business days after June 16, 2014 (the effective
 9 date of Public Act 98-651).

10 (7.13) In addition to any other transfers authorized
 11 under this Section, for State fiscal years 2017 and 2018,
 12 for making transfers to the Healthcare Provider Relief
 13 Fund of moneys collected from the ACA Assessment
 14 Adjustment authorized under subsections (a) and (b-5) of
 15 Section 5A-2 and paid by hospital providers under Section
 16 5A-4 into the Hospital Provider Fund under Section 5A-6
 17 for each State fiscal year. Timing of transfers to the
 18 Healthcare Provider Relief Fund under this paragraph shall
 19 be at the discretion of the Department, but no less
 20 frequently than quarterly.

21 (7.14) For making transfers not exceeding the
 22 following amounts, related to State fiscal years 2019 and
 23 2020, to the following designated funds:

24	Health and Human Services Medicaid Trust	
25	Fund	\$20,000,000
26	Long-Term Care Provider Fund	\$30,000,000

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

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

6 (7.15) For making transfers not exceeding the
7 following amounts, related to State fiscal years 2023
8 through 2024 ~~2026~~, to the following designated funds:

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

13 (7.16) For making transfers not exceeding the
14 following amounts, related to July 1, 2024 ~~2026~~ to
15 December 31, 2024 ~~2026~~, to the following designated funds:

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

20 (7.17) For making transfers not exceeding the
21 following amounts, related to calendar years 2025 and each
22 calendar year thereafter, the following designated funds:

- 23 Health and Human Services Medicaid Trust
- 24 Fund \$20,000,000
- 25 Long-Term Care Provider Fund \$30,000,000
- 26 Healthcare Provider Relief Fund.... \$505,637,082;

1 however the amount shall remain \$365,000,000 until the
2 reimbursement rates described in subsection (r) of Section
3 5A-12.7 are fully implemented. If for any reason the
4 assessment imposed by subsection (a) or (b-5) of Section 5A-2
5 is reduced, the amount of \$505,637,082 shall be reduced by the
6 same percentage.

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

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

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

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

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

26 (1) All moneys collected or received by the Illinois

1 Department from the hospital provider assessment imposed
2 by this Article.

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

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

9 (3.5) As applicable, proceeds from surety bond
10 payments payable to the Department as referenced in
11 subsection (s) of Section 5A-12.2 of this Code.

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

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

16 (d) (Blank).

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

18 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

19 Sec. 5A-10. Applicability.

20 (a) The assessment imposed by subsection (a) of Section
21 5A-2 shall cease to be imposed and the Department's obligation
22 to make payments shall immediately cease, and any moneys
23 remaining in the Fund shall be refunded to hospital providers
24 in proportion to the amounts paid by them, if:

25 (1) The payments to hospitals required under this

1 Article are not eligible for federal matching funds under
2 Title XIX or XXI of the Social Security Act;

3 (2) For State fiscal years 2009 through 2018, and as
4 provided in Section 5A-16, the Department of Healthcare
5 and Family Services adopts any administrative rule change
6 to reduce payment rates or alters any payment methodology
7 that reduces any payment rates made to operating hospitals
8 under the approved Title XIX or Title XXI State plan in
9 effect January 1, 2008 except for:

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

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

14 (C) any changes proposed in State plan amendment
15 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
16 08-07;

17 (D) in relation to any admissions on or after
18 January 1, 2011, a modification in the methodology for
19 calculating outlier payments to hospitals for
20 exceptionally costly stays, for hospitals reimbursed
21 under the diagnosis-related grouping methodology in
22 effect on July 1, 2011; provided that the Department
23 shall be limited to one such modification during the
24 36-month period after the effective date of this
25 amendatory Act of the 96th General Assembly;

26 (E) any changes affecting hospitals authorized by

1 Public Act 97-689;

2 (F) any changes authorized by Section 14-12 of
3 this Code, or for any changes authorized under Section
4 5A-15 of this Code; or

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

6 (b) The assessment imposed by Section 5A-2 shall not take
7 effect or shall cease to be imposed, and the Department's
8 obligation to make payments shall immediately cease, if the
9 assessment is determined to be an impermissible tax under
10 Title XIX of the Social Security Act. Moneys in the Hospital
11 Provider Fund derived from assessments imposed prior thereto
12 shall be disbursed in accordance with Section 5A-8 to the
13 extent federal financial participation is not reduced due to
14 the impermissibility of the assessments, and any remaining
15 moneys shall be refunded to hospital providers in proportion
16 to the amounts paid by them.

17 (c) The assessments imposed by subsection (b-5) of Section
18 5A-2 shall not take effect or shall cease to be imposed, the
19 Department's obligation to make payments shall immediately
20 cease, and any moneys remaining in the Fund shall be refunded
21 to hospital providers in proportion to the amounts paid by
22 them, if the payments to hospitals required under Section
23 5A-12.4 or Section 5A-12.6 are not eligible for federal
24 matching funds under Title XIX of the Social Security Act.

25 (d) The assessments imposed by Section 5A-2 shall not take
26 effect or shall cease to be imposed, the Department's

1 obligation to make payments shall immediately cease, and any
2 moneys remaining in the Fund shall be refunded to hospital
3 providers in proportion to the amounts paid by them, if:

4 (1) for State fiscal years 2013 through 2018, and as
5 provided in Section 5A-16, the Department reduces any
6 payment rates to hospitals as in effect on May 1, 2012, or
7 alters any payment methodology as in effect on May 1,
8 2012, that has the effect of reducing payment rates to
9 hospitals, except for any changes affecting hospitals
10 authorized in Public Act 97-689 and any changes authorized
11 by Section 14-12 of this Code, and except for any changes
12 authorized under Section 5A-15, and except for any changes
13 authorized under Section 5-5b.1;

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

24 (3) for State fiscal years 2015 through 2018, and as
25 provided in Section 5A-16, the Department reduces the
26 overall effective rate of reimbursement to hospitals below

1 the level authorized under Section 14-12 of this Code,
2 except for any changes under Section 14-12 or Section
3 5A-15 of this Code, and except for any changes authorized
4 under Section 5-5b.1.

5 (e) In State fiscal year 2019 through State fiscal year
6 2020, the assessments imposed under Section 5A-2 shall not
7 take effect or shall cease to be imposed, the Department's
8 obligation to make payments shall immediately cease, and any
9 moneys remaining in the Fund shall be refunded to hospital
10 providers in proportion to the amounts paid by them, if:

11 (1) the payments to hospitals required under Section
12 5A-12.6 are not eligible for federal matching funds under
13 Title XIX of the Social Security Act; or

14 (2) the Department reduces the overall effective rate
15 of reimbursement to hospitals below the level authorized
16 under Section 14-12 of this Code, as in effect on December
17 31, 2017, except for any changes authorized under Sections
18 14-12 or Section 5A-15 of this Code, and except for any
19 changes authorized under changes to Sections 5A-12.2,
20 5A-12.4, 5A-12.5, 5A-12.6, and 14-12 made by Public Act
21 100-581.

22 (f) Beginning in State Fiscal Year 2021 through December
23 31, 2024, the assessments imposed under Section 5A-2 shall not
24 take effect or shall cease to be imposed, the Department's
25 obligation to make payments shall immediately cease, and any
26 moneys remaining in the Fund shall be refunded to hospital

1 providers in proportion to the amounts paid by them, if:

2 (1) the payments to hospitals required under Section
3 5A-12.7 are not eligible for federal matching funds under
4 Title XIX of the Social Security Act; or

5 (2) the Department reduces the overall effective rate
6 of reimbursement to hospitals below the level authorized
7 under Section 14-12, as in effect on December 31, 2021,
8 except for any changes authorized under Sections 14-12 or
9 5A-15, and except for any changes authorized under changes
10 to Sections 5A-12.7 and 14-12 made by this amendatory Act
11 of the 101st General Assembly, and except for any changes
12 to Section 5A-12.7 made by this amendatory Act of the
13 102nd General Assembly.

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

17 (1) the payments to hospitals required under Section
18 5A-12.7 are not eligible for federal matching funds under
19 Title XIX of the Social Security Act; or

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

25 (h) To provide for the expeditious and timely
26 implementation of the changes made to this Section by this

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

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

7 (305 ILCS 5/5A-12.7)

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

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

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

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

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

8 (c) Graduate medical education.

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

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

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

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

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

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

26 (B) Beginning ~~For the period of~~ January 1, 2023

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

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

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

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

1 \$625 per paid fee-for-service outpatient claim for dates
2 of service in Calendar Year 2019 in the Department's
3 Enterprise Data Warehouse as of May 11, 2020.

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

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

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

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

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

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

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

1 the original rates set forth in this subsection.

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

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

14 (3) For long term acute care hospitals, \$550 per
15 covered inpatient day contained in paid fee-for-service
16 claims for dates of service in Calendar Year 2019 in the
17 Department's Enterprise Data Warehouse as of August 6,
18 2021.

19 (4) For freestanding psychiatric hospitals, \$200 per
20 covered inpatient day contained in paid fee-for-service
21 claims and \$200 per paid fee-for-service outpatient claim
22 for dates of service in Calendar Year 2019 in the
23 Department's Enterprise Data Warehouse as of August 6,
24 2021.

25 (5) For freestanding rehabilitation hospitals, \$550
26 per covered inpatient day contained in paid

1 fee-for-service claims and \$125 per paid fee-for-service
2 outpatient claim for dates of service in Calendar Year
3 2019 in the Department's Enterprise Data Warehouse as of
4 August 6, 2021.

5 (6) For all general acute care hospitals and high
6 Medicaid hospitals as defined in subsection (f), \$500 per
7 covered inpatient day for dates of service in Calendar
8 Year 2019 contained in paid fee-for-service claims and
9 \$500 per paid fee-for-service outpatient claim in the
10 Department's Enterprise Data Warehouse as of August 6,
11 2021.

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

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

1 of the qualifying hospital's Calendar Year 2019 total
2 inpatient fee-for-service days, in the Department's
3 Enterprise Data Warehouse as of August 6, 2021, multiplied
4 by the applicable Alzheimer's treatment rate of \$244.37
5 for hospitals located in Cook County and \$312.03 for
6 hospitals located outside Cook County.

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

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

26 (f) (1) For purposes of allocating the funds included in

1 capitation payments to MCOs, Illinois hospitals shall be
2 divided into the following classes as defined in
3 administrative rules:

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

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

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

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

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

10 (C) Long term acute care hospitals.

11 (D) Freestanding psychiatric hospitals.

12 (E) Freestanding rehabilitation hospitals.

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

18 (G) High Medicaid hospitals.

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

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

1 July 1, 2020 through December 31, 2020, the
2 applicable period for the Medicaid Inpatient
3 Utilization Rate (MIUR) is the rate year 2020 MIUR
4 and for the number of inpatient days it is State
5 fiscal year 2018. Beginning in calendar year 2021,
6 the Department shall use the most recently
7 determined MIUR, as defined in subsection (h) of
8 Section 5-5.02, and for the inpatient day
9 threshold, the State fiscal year ending 18 months
10 prior to the beginning of the calendar year. For
11 purposes of calculating MIUR under this Section,
12 children's hospitals and affiliated general acute
13 care hospitals shall be considered a single
14 hospital.

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

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

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

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

1 through (G).

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

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

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

1 services rendered by safety-net hospitals and critical access
2 hospitals to determine a quarterly uniform per unit add-on for
3 each hospital class.

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

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

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

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

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

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

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

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

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

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

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

26 (A) \$2,894,500 for hospital inpatient services for

1 critical access hospitals.

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

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

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

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

24 (A) Hospital inpatient services for critical
25 access hospitals.

26 (B) Hospital outpatient services for critical

1 access hospitals.

2 (C) Hospital inpatient services for public
3 hospitals.

4 (D) Hospital outpatient services for public
5 hospitals.

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

8 (F) Hospital outpatient services for safety-net
9 hospitals.

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

1 the service units from calendar year 2021 shall be used.

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

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

17 (h) Fixed rate directed payments. Effective July 1, 2020,
18 the Department shall issue payments to MCOs which shall be
19 used to issue directed payments to Illinois hospitals not
20 identified in paragraph (g) on a monthly basis. Prior to the
21 beginning of each Payout Quarter beginning July 1, 2020, the
22 Department shall use encounter claims data from the
23 Determination Quarter, accepted by the Department's Medicaid
24 Management Information System for inpatient and outpatient
25 services rendered by hospitals in each hospital class
26 identified in paragraph (f) and not identified in paragraph

1 (g). For the period July 1, 2020 through December 2020, the
2 Department shall direct MCOs to make payments as follows:

3 (1) For general acute care hospitals an amount equal
4 to \$1,750 multiplied by the hospital's category of service
5 20 case mix index for the determination quarter multiplied
6 by the hospital's total number of inpatient admissions for
7 category of service 20 for the determination quarter.

8 (2) For general acute care hospitals an amount equal
9 to \$160 multiplied by the hospital's category of service
10 21 case mix index for the determination quarter multiplied
11 by the hospital's total number of inpatient admissions for
12 category of service 21 for the determination quarter.

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

18 (4) For general acute care hospitals an amount equal
19 to \$375 multiplied by the hospital's category of service
20 24 case mix index for the determination quarter multiplied
21 by the hospital's total number of category of service 24
22 paid EAPG (EAPGs) for the determination quarter.

23 (5) For general acute care hospitals an amount equal
24 to \$240 multiplied by the hospital's category of service
25 27 and 28 case mix index for the determination quarter
26 multiplied by the hospital's total number of category of

1 service 27 and 28 paid EAPGs for the determination
2 quarter.

3 (6) For general acute care hospitals an amount equal
4 to \$290 multiplied by the hospital's category of service
5 29 case mix index for the determination quarter multiplied
6 by the hospital's total number of category of service 29
7 paid EAPGs for the determination quarter.

8 (7) For high Medicaid hospitals an amount equal to
9 \$1,800 multiplied by the hospital's category of service 20
10 case mix index for the determination quarter multiplied by
11 the hospital's total number of inpatient admissions for
12 category of service 20 for the determination quarter.

13 (8) For high Medicaid hospitals an amount equal to
14 \$160 multiplied by the hospital's category of service 21
15 case mix index for the determination quarter multiplied by
16 the hospital's total number of inpatient admissions for
17 category of service 21 for the determination quarter.

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

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

1 EAPG outpatient claims for the determination quarter.

2 (11) For high Medicaid hospitals an amount equal to
3 \$240 multiplied by the hospital's category of service 27
4 and 28 case mix index for the determination quarter
5 multiplied by the hospital's total number of category of
6 service 27 and 28 paid EAPGs for the determination
7 quarter.

8 (12) For high Medicaid hospitals an amount equal to
9 \$290 multiplied by the hospital's category of service 29
10 case mix index for the determination quarter multiplied by
11 the hospital's total number of category of service 29 paid
12 EAPGs for the determination quarter.

13 (13) For long term acute care hospitals the amount of
14 \$495 multiplied by the hospital's total number of
15 inpatient days for the determination quarter.

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

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

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

1 quarter.

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

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

1 payment amounts to be established under this subsection on
2 its website by November 15, 2022.

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

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

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

20 Definitions. As used in this subsection:

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

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

26 (C) "Case mix index" means a hospital specific

1 calculation. For inpatient claims the case mix index
2 is calculated each quarter by summing the relative
3 weight of all inpatient Diagnosis-Related Group (DRG)
4 claims for a category of service in the applicable
5 Determination Quarter and dividing the sum by the
6 number of sum total of all inpatient DRG admissions
7 for the category of service for the associated claims.
8 The case mix index for outpatient claims is calculated
9 each quarter by summing the relative weight of all
10 paid EAPGs in the applicable Determination Quarter and
11 dividing the sum by the sum total of paid EAPGs for the
12 associated claims.

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

20 (1) Beginning January 1, 2024, the fixed pool directed
21 payment amounts and the associated annual initial rates
22 referenced in paragraph (6) of subsection (f) for each
23 hospital class shall be uniformly increased by a ratio of
24 not less than, the ratio of the total pass-through
25 reduction amount pursuant to paragraph (4) of subsection
26 (j), for the hospitals comprising the hospital fixed pool

1 directed payment class for the next calendar year, to the
2 total inpatient and outpatient directed payments for the
3 hospitals comprising the hospital fixed pool directed
4 payment class paid during the preceding calendar year.

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

16 (j) Pass-through payments.

17 (1) For the period July 1, 2020 through December 31,
18 2020, the Department shall assign quarterly pass-through
19 payments to each class of hospitals equal to one-fourth of
20 the following annual allocations:

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

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

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

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

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

26 (F) \$40,825,444 to freestanding psychiatric

1 hospitals.

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

4 (2) For the period of July 1, 2020 through December
5 31, 2020, the pass-through payments shall at a minimum
6 ensure hospitals receive a total amount of monthly
7 payments under this Section as received in calendar year
8 2019 in accordance with this Article and paragraph (1) of
9 subsection (d-5) of Section 14-12, exclusive of amounts
10 received through payments referenced in subsection (b).

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

26 (4) For the calendar years beginning January 1, 2021

1 and January 1, 2022, each hospital's pass-through payment
2 amount shall be reduced proportionally to the reduction of
3 all pass-through payments required by federal regulations.
4 Beginning January 1, 2024, the Department shall reduce
5 total pass-through payments by the minimum amount
6 necessary to comply with federal regulations. Pass-through
7 payments to safety-net hospitals, as defined in Section
8 5-5e.1 of this Code, shall not be reduced until all
9 pass-through payments to other hospitals have been
10 eliminated. All other hospitals shall have their
11 pass-through payments reduced proportionally.

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

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

26 (m) As used in this subsection, "managed care

1 organization" or "MCO" means an entity which contracts with
2 the Department to provide services where payment for medical
3 services is made on a capitated basis, excluding contracted
4 entities for dual eligible or Department of Children and
5 Family Services youth populations.

6 (n) In order to address the escalating infant mortality
7 rates among minority communities in Illinois, the State shall,
8 subject to appropriation, create a pool of funding of at least
9 \$50,000,000 annually to be disbursed among safety-net
10 hospitals that maintain perinatal designation from the
11 Department of Public Health. The funding shall be used to
12 preserve or enhance OB/GYN services or other specialty
13 services at the receiving hospital, with the distribution of
14 funding to be established by rule and with consideration to
15 perinatal hospitals with safe birthing levels and quality
16 metrics for healthy mothers and babies.

17 (o) In order to address the growing challenges of
18 providing stable access to healthcare in rural Illinois,
19 including perinatal services, behavioral healthcare including
20 substance use disorder services (SUDs) and other specialty
21 services, and to expand access to telehealth services among
22 rural communities in Illinois, the Department of Healthcare
23 and Family Services shall administer a program to provide at
24 least \$10,000,000 in financial support annually to critical
25 access hospitals for delivery of perinatal and OB/GYN
26 services, behavioral healthcare including SUDs, other

1 specialty services and telehealth services. The funding shall
2 be used to preserve or enhance perinatal and OB/GYN services,
3 behavioral healthcare including SUDS, other specialty
4 services, as well as the explanation of telehealth services by
5 the receiving hospital, with the distribution of funding to be
6 established by rule.

7 (p) For calendar year 2023, the final amounts, rates, and
8 payments under subsections (c), (d-2), (g), (h), and (j) shall
9 be established by the Department, so that the sum of the total
10 estimated annual payments under subsections (c), (d-2), (g),
11 (h), and (j) for each hospital class for calendar year 2023, is
12 no less than:

13 (1) \$858,260,000 to safety-net hospitals.

14 (2) \$86,200,000 to critical access hospitals.

15 (3) \$1,765,000,000 to high Medicaid hospitals.

16 (4) \$673,860,000 to general acute care hospitals.

17 (5) \$48,330,000 to long term acute care hospitals.

18 (6) \$89,110,000 to freestanding psychiatric hospitals.

19 (7) \$24,300,000 to freestanding rehabilitation
20 hospitals.

21 (8) \$32,570,000 to public hospitals.

22 (q) Hospital Pandemic Recovery Stabilization Payments. The
23 Department shall disburse a pool of \$460,000,000 in stability
24 payments to hospitals prior to April 1, 2023. The allocation
25 of the pool shall be based on the hospital directed payment
26 classes and directed payments issued, during Calendar Year

1 2022 with added consideration to safety net hospitals, as
2 defined in subdivision (f) (1) (B) of this Section, and critical
3 access hospitals.

4 (r) Directed payment update. For calendar year 2025, and
5 each calendar year thereafter, the final amounts, rates, and
6 payments for the fixed pool directed payments described in
7 subsection (g) and the fixed rate directed payments described
8 in subsection (h) shall be established by the Department at no
9 less than the following:

10 (1) \$579,261,585 for inpatient services at safety-net
11 hospitals.

12 (2) \$763,418,138 for outpatient services at safety-net
13 hospitals.

14 (3) \$12,389,160 for inpatient services at critical
15 access hospitals.

16 (4) \$137,437,866 for outpatient services at critical
17 access hospitals.

18 (5) \$5,418 as a base fixed rate per admit prior to
19 adjusting for acuity, for inpatient services at high
20 Medicaid hospitals.

21 (6) \$1,512 as a base fixed rate per paid E-APG prior to
22 adjusting for acuity, for outpatient services at high
23 Medicaid hospitals.

24 (7) \$3,898 as a base fixed rate per admit prior to
25 adjusting for acuity, for inpatient services at other
26 acute care hospitals.

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

4 (9) \$773 per day for inpatient services at long term
5 acute care hospitals.

6 (10) \$206 per day for inpatient services at
7 freestanding psychiatric hospitals.

8 (11) \$223 per claim for outpatient services at
9 freestanding psychiatric hospitals.

10 (12) \$776 per day for inpatient services at
11 freestanding rehabilitation hospitals.

12 (13) \$252 per claim for outpatient services at
13 freestanding rehabilitation hospitals.

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

16 (15) \$26,849,592 for outpatient services at public
17 hospitals.

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

26 (s) If, in order to secure approval by the Centers for

1 Medicare and Medicaid Services, the rates under subsection (r)
2 are reduced, the Department may submit a State Plan amendment
3 to increase rates in place at the time of the reduction
4 pertaining to subsection (d-2) to offset the annual amount of
5 reduction to the rates under subsection (r), in amounts equal
6 to the required reduction on a class-specific basis to ensure
7 that funds are not reallocated from one class to another; or
8 the rates in subsection (r) shall be reduced uniformly to the
9 amounts necessary to achieve approval and the assessments
10 imposed by subsection (a) or (b-5) of Section 5A-2 shall be
11 reduced uniformly to achieve a total annual reduction across
12 both assessments equal to the product of the total annual
13 reduction to payments and .3853. In addition, the assessments
14 shall further be reduced uniformly to achieve a total annual
15 reduction across both assessments equal to the difference of
16 subtracting the product calculated in the previous sentence
17 from the resulting quotient of dividing the product described
18 in the previous sentence by .92 for a reduction to the
19 transfers in subsection 7.16 and 7.17 of Section 5A-8.

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

1 (Source: P.A. 102-4, eff. 4-27-21; 102-16, eff. 6-17-21;
2 102-886, eff. 5-17-22; 102-1115, eff. 1-9-23; 103-102, eff.
3 6-16-23; 103-593, eff. 6-7-24; 103-605, eff. 7-1-24.)

4 (305 ILCS 5/5A-14)

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

6 (a) (Blank). ~~Section 5A-2 is repealed on December 31,~~
7 ~~2026.~~

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

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

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

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

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

14 (g) (Blank). ~~Section 5A-12.7 is repealed on December 31,~~
15 ~~2026.~~

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

17 (305 ILCS 5/12-4.105)

18 Sec. 12-4.105. Human poison control center; payment
19 program. Subject to funding availability resulting from
20 transfers made from the Hospital Provider Fund to the
21 Healthcare Provider Relief Fund as authorized under this Code,
22 for State fiscal year 2017 and State fiscal year 2018, and for
23 each State fiscal year thereafter in which the assessment
24 under Section 5A-2 is imposed, the Department of Healthcare

1 and Family Services shall pay to the human poison control
2 center designated under the Poison Control System Act an
3 amount of not less than \$3,000,000 for each of State fiscal
4 years 2017 through 2020, and for State fiscal years 2021
5 through 2023 an amount of not less than \$3,750,000 and for
6 State fiscal ~~year years~~ 2024 ~~through 2026~~ an amount of not less
7 than \$4,000,000, and for State fiscal year 2025 an amount not
8 less than \$4,500,000, and for State fiscal year 2026, and each
9 fiscal year thereafter, an amount of not less than \$4,750,000
10 ~~and for the period July 1, 2026 through December 31, 2026 an~~
11 ~~amount of not less than \$2,000,000, if the human poison~~
12 control center is in operation.

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

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