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State/Territory Name: IL

State Plan Amendment (SPA) #: 14-014A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JAN 06 2016

Felicia Norwood, Director
Illinois Department of Healthcare and Family Services
Prescott E Bloom Building
201 South Grand Avenue East
Springfield IL 62763-0002

RE: Illinois State Plan Amendment (SPA) 14-014A

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-014A. Effective July 1, 2014 this state plan amendment (SPA) makes comprehensive revisions to large sections of the inpatient and outpatient service definition and reimbursement sections of the state plan.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 14-014A is approved effective July 1, 2014. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Fredrick Sebree, of my staff, at (217) 492-4122 or by e-mail at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14-0014A

2. STATE: ILLINOIS

3. PROGRAM IDENTIFICATION: Title XIX of the *Social Security Act* (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section ~~1932(a)~~ of the *Social Security Act*
1905(a)(1) and 1905(a)(2)(A)

7. FEDERAL BUDGET IMPACT
a. FFY 2015: $ 14.4 MILLION
b. FFY 2016: $ 37.5 MILLION

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A pg 1-1(A)~~(10).1~~ (a), 2(A), 7C, 10C
Attachment 4.19-B pg 1, 10-19~~.1~~, 20.1, 21.1-25l, ~~48~~ 48A, 50-52A, ~~57~~ 56-58, 60l
Attachment 4.19-A pg 1-~~11.1~~ 10.1, 14-15, ~~17~~, 19, ~~20B~~ 20C-22, 30-37, 39-51A ~~50-52~~ 52-75, 78-79, 82-86, 88, 90-111, 113-131D1, 131G, 131M-131M~~14~~ 6, 135-~~136~~ 140, 138-~~139~~ 144, 143-144, 156-160, 168, 170,

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE Box 23
140, 155, 155A

10. SUBJECT OF AMENDMENT:
Hospital Inpatient and Outpatient Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*
[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Julie Hamos

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED: 3-11-14

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Reimbursement Analysis
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 06 2016

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMC

23. REMARKS:
APPENDIX TO ATTACHMENT 3.1-A: 1, 1A, 1A1-1A9, 2A
ATTACHMENT 4.19A: 1-11, 14-15, 19, 20C, 21-22, 30-37, 39-42, 42A, 43-48, 50-51, 51A 52-52A, 53-56, 56A, 57-63, 63A-63G, 64-74, 74A-74B, 75, 78-79, 82, 82A, 83-86 88, 90-111, 113-118, 118A, 119-126, 126A, 127, 127A, 128-131, 131A-131A1, 131B, 131B1, 131B2, 131C, 131C1, 131C2, 131D, 131D1, 131G, 131M, 131M1-131M6, 135-140, 143, 144, 155, 155A, 156-160, 168.
ATTACHMENT 4.19-B: 1, 10-19, 22-25, 25A-25I, 48A, 50-52, 56-58, 60I.

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

I. General Provisions

07/14~~09/91~~ A. Scope

1. Effective ~~October 1, 1992~~ July 1, 2014, the Department shall reimburse hospitals for inpatient services rendered to persons receiving coverage under the Medicaid Program by either: 1) a Diagnosis Related Grouping System (DRGs) prospective payment system (PPS), 2) a cost-based per diem system, or 3) a non-cost-based per diem system. All three reimbursement systems are prospective in nature and hospitals may keep the difference between their payment rate and the actual costs incurred in furnishing inpatient services and are at risk for costs that exceed their payment rates. Additional payments will be made for outlier cases, certain costs excluded from the prospective payment rate, disproportionate share hospitals, and uncompensated care. ~~specific inpatient adjustments, primary care access health care education, certified registered nurse anesthetist (CRNA) costs, and for kidney acquisition costs.~~

~~2. Notwithstanding any other provisions of Chapters I. through XIV reimbursement to hospitals for services provided October 1, 1992, through March 31, 1994, shall be as follows:~~

~~a. Base Inpatient Payment Rate. For inpatient hospital services rendered, or, if applicable, for inpatient hospital admissions occurring, on and after October 1, 1993, and on or before March 31, 1994, the Department shall reimburse hospitals for inpatient services at the inpatient payment rate calculated for each hospital, as of June 30, 1993. The term "base inpatient payment rate" shall include the reimbursement rates calculated effective October 1, 1992, under the following Chapters: Chapters I. through V., Chapter VI, Section G., and Chapters VII through VIII.~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

[MATERIAL REMOVED]

~~10/93~~

~~b. Exceptions The provisions of Section A.2.a.above shall not apply to:~~

~~i) Hospitals reimbursed under Chapters X., XIII, or XIV. Reimbursement for such hospitals shall be in accordance with Chapters X., XIII, or XIV, as applicable.~~

~~ii) Hospitals reclassified as rural hospitals as described in Section H.4 of Chapter VIII. Reimbursement for such hospitals shall be in accordance with Section H.4 of Chapter VIII, and Section A.2 of Chapter VIII, or Section B.2.of Chapter IV, whichever is applicable.~~

~~iii) The inpatient payment adjustments described in Chapter VI, Sections A. through F. Reimbursement for such inpatient payments adjustments shall be in accordance with Chapter VI, Sections A. through F., and shall be in addition to the base inpatient payment rate described in Section 2.a. above.~~

~~B. Summary~~

~~This Chapter describes the basis of payment for inpatient hospital services under the DRG PPS and sets forth the general basis for the system. Chapter II sets forth the classifications of hospitals that are included and excluded from the DRG PPS and sets forth requirements governing inclusion or exclusion of hospitals in the system as a result of changes in their classification. Chapter III sets forth certain conditions that must be met for a hospital to receive payment under the DRG PPS. Chapter IV sets forth the methodology by which DRG prospective payment rates are determined. Chapter V. sets forth the methodology for determining additional payments for outlier cases. Chapter VI sets forth rules for special treatment of certain facilities. Chapter VII describes the types, amounts and methods of payment to hospitals under the DRG PPS. Chapter VIII describes the payment for hospitals subject to alternative reimbursement systems. Chapter IX describes the review procedures for payment reviews. Chapter X. describes reimbursement for transplant care, Chapter XI describes reimbursement for inappropriate level of care and Chapter XII describes alternatives. Chapter XIII describes reimbursement for county-owned hospitals in a county with a population of over 3 million. Chapter XIV describes reimbursement for state-owned hospitals organized under the University of Illinois Hospital Act. Chapter XV describes definitions and applicability of terms used throughout this plan.~~

09/91 B~~C.~~Basis of Payment

1. Payment on a Per Discharge Basis

   a. Under the DRG PPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

10/92

b. The DRG prospective payment rate for each discharge ~~(as defined in Section D of this Chapter)~~ is determined according to the methodology described in Chapters IV. ~~and VII, as appropriate.~~ An additional payment is made, in accordance with ~~Chapter V. and~~ Chapter VI and Chapter XV, as appropriate. The rates paid shall be those in effect on the date of service ~~admission~~.

2. Payment in Full

a. The DRG prospective payment amount paid for inpatient hospital services is the total Medicaid payment for the inpatient operating costs ~~(as described in Section C.3. below)~~ incurred in furnishing services covered under the Medicaid Program.

b. ~~Except as provided for in Section D. of this Chapter, the~~ The full DRG prospective payment amount, as determined under Chapters IV ~~and VII, as appropriate~~, is made for each stay during which there is at least one Medicaid eligible day of care.

~~3. Inpatient Operating Costs~~

~~The DRG PPS provides a payment amount for inpatient operating costs, including:~~

~~a. Operating costs for routine services (as described in 42 CFR 413.53(b), revised as of September 1, 1990), such as the costs of room, board, and routine nursing services~~

~~b. Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;~~

~~c. Special care unit operating costs (intensive care type unit services as described in 42 CFR 413.53(b), revised as of September 1, 1990); and~~

~~d. Malpractice insurance costs related to services furnished to inpatients.~~

[MATERIAL REMOVED]

~~10/93~~ ~~e. Hospital-based physician costs as described in Section G. of Chapter III.~~

~~4. Excluded Costs/Services~~

~~The following inpatient hospital costs are excluded from the DRG prospective payment amounts:~~

~~07/95~~ ~~a. Transplantation costs, including acquisition costs incurred by approved transplantation centers as described in Chapter X. Kidney and cornea transplant costs shall be reimbursed under the appropriate methodology described in Chapters IV and VII, or in Chapter VIII, Chapter XIII or Chapter XIV, as appropriate.~~

~~10/92~~ ~~b. Costs of psychiatric services incurred by a provider enrolled with the Department to provide those services (category of service 21). Such services shall be reimbursed in accordance with Chapter VIII, Chapter XIII, or Chapter XIV, as appropriate.~~

~~c. Costs of non-emergency psychiatric services incurred by a provider that is not enrolled with the Department to provide those services (category of service 21). Such services shall not be eligible for reimbursement.~~

~~d. Costs of emergency psychiatric services exceeding the maximum of three days emergency treatment incurred by a provider that is not enrolled with the Department to provide those services (DRG's 424-432). Such services exceeding the maximum of three days shall not be eligible for reimbursement.~~

[MATERIAL REMOVED]

~~10/92~~ ~~e. Costs of physical rehabilitation services incurred by a provider enrolled with the Department to provide those services (category of service 22). Such services shall be reimbursed in accordance with Chapter VIII, Chapter XIII, or Chapter XIV, as appropriate.~~

~~10/92~~ ~~f. Costs of rehabilitation for drug and alcohol abuse (DRG 436 and that part of DRG 437 apportioned to rehabilitation). Such services shall not be reimbursed as hospital services.~~

~~5. Additional Payments to Hospitals~~

~~In addition to payments based on the DRG prospective payment rates, hospitals will receive payments for the following:~~

~~a. A typically long or extraordinarily costly (outlier) cases, as described in Chapter V.~~

~~b. Certain costs excluded from the prospective payment rate under Section C.4 of this Chapter.~~

~~10/92~~ ~~c. The cost of serving a disproportionately high share of low income patients (as defined and determined in Chapter VI.).~~

~~07/95~~ ~~d. Specific inpatient payment adjustments (as defined and determined in Chapter VI and Chapter XV.).~~

[MATERIAL REMOVED]

~~09/91~~ ~~D. Discharges and Transfers~~

~~1. Discharges~~

~~A hospital inpatient is considered discharged when any of the following occurs:~~

~~a. The patient is formally released from the hospital except when the patient is transferred to another hospital or a distinct part unit as described in Chapter II. (See section D.2. of this Chapter).~~

~~b. The patient dies in the hospital.~~

~~2. Transfers~~

~~A hospital inpatient is considered transferred when the patient is placed in the care of another hospital or a distinct part unit as described in Chapter II.~~

~~3. Payment in Full to the Discharging Hospital~~

~~10/92~~ ~~The hospital discharging an inpatient (under Section D.1.a. of this Chapter) is paid in full, in accordance with Section C.2 of this Chapter unless the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS as described in Chapter II. In the event the discharging hospital or distinct part unit is excluded or exempted from the DRG PPS, that hospital or distinct part unit shall receive payment in full in accordance with Chapter VIII Chapter X., Chapter XIII, or Chapter XIV, as appropriate.~~

[MATERIAL REMOVED]

~~4. Payment to a Hospital Transferring an Inpatient to Another Hospital or Distinct Part Unit~~

~~a. A hospital reimbursed under the DRG PPS that transfers an inpatient, under the circumstances described in Section D.2, is paid a per diem rate for each day of the patient's stay in that hospital but the total reimbursement shall not exceed the amount that would have been paid under Chapter IV if the patient had been discharged. The per diem rate is determined by dividing the appropriate prospective payment rate (as determined under Chapter IV.) by the geometric length of stay for the specific DRG to which the case is classified.~~

~~b. Except, if a discharge is classified into DRG 385 (neonates, died or transferred to another acute care facility) or DRG 456 (burns, transferred to another acute care facility), and the hospital is reimbursed under the DRG PPS, the transferring hospital is paid in accordance with Section C.2 of this Chapter.~~

~~c. A transferring hospital reimbursed under the DRG PPS may qualify for an additional payment for extraordinarily high cost cases that meet the criteria for cost outliers as described in Chapter V.~~

~~10/92~~ ~~d. A hospital or distinct part unit excluded from the DRG PPS, as described in Chapter I., that transfers an inpatient under the circumstances described in Section D.2 of this Chapter, is reimbursed in accordance with Chapter VIII, Chapter XII, Chapter XIII, or Chapter XIV, as applicable.~~

[MATERIAL REMOVED]

~~09/91~~ ~~E. Admissions Prior to September 1, 1991~~

~~With respect to admissions prior to September 1, 1991, hospitals will receive their per diem reimbursement rate that was in effect July 1, 1991, for each covered day of care provided through the discharge of the patient.~~

~~09/91~~ ~~F. DRG Classification System~~

~~10/93~~ ~~1. The Department will utilize the DRG Grouper, as described in Section B.5 of Chapter XV, modified to handle additional DRG's and revised ICD-9-CM codes, as defined by the Department, to place claims into DRG payment classifications.~~

~~2. The Department will define additional DRG's that, for hospitals designated as Level III perinatal centers by the Illinois Department of Public Health, replace DRG 385 (neonates, died or transferred to another acute care facility), DRG 386 (extreme immaturity or respiratory distress syndrome, neonate), DRG 387 (prematurity with major problems) and DRG 389 (full term neonate with major problems).~~

07/14 II. Hospital Inpatient Services Subject to and Excluded from the DRG Prospective Payment System

A. Inpatient services subject to submission for DRG grouping. All hospital inpatient services provided to enrollees of the Medical Assistance programs, without regard to balance due or expected reimbursement methodology to be applied by the Department, must be documented on a claim and submitted to the Department. The Department shall process and group all hospital inpatient claims through the DRG grouper.

~~09/91~~ ~~A. Hospital Services Subject to the DRG Prospective Payment System~~

~~1. Except for services described in Section C.4 of Chapter I. and Section B.2 of this Chapter, all covered inpatient hospital services furnished to persons receiving coverage under the Medicaid Program are paid for under the DRG PPS.~~

~~2. Inpatient hospital services will not be paid for under the DRG PPS under any of the following circumstances:~~

~~a. The services are furnished by a hospital (or distinct part hospital unit) explicitly excluded from the DRG PPS under Sections C. through D. of this Chapter.~~

~~b. The services are furnished by a nonparticipating out-of-state hospital (as described in Section C.5. of this Chapter).~~

~~c. The services are furnished by a hospital that elects to be reimbursed under special arrangements (as described in Section C.6. of this Chapter) in the transition period of DRG PPS implementation.~~

~~10/92~~ ~~d. The services are furnished by a sole community hospital (as defined in Chapter VI.B.1.) that has elected to be exempted from the DRG PPS in accordance with~~ Section C.7 of this Chapter.

~~e. The payment for services is covered by a health maintenance organization (HMO).~~

B. Excluded from DRG PPS reimbursements are:

1. Psychiatric services provided by:
   a. A psychiatric hospital, as described in Chapter VIII.
   b. A distinct part of psychiatric unit, as described in Chapter VIII.
2. Physical rehabilitation services provided by:
   a. A rehabilitation hospital, as described in Chapter VIII.
   b. A distinct part rehabilitation unit, as described in Chapter VIII.
3. Services provided by a long term acute care hospital, as described in Chapter VIII that are not psychiatric services or services described in subsections 1.and 2. of this Section.
4. Inpatient services reimbursed pursuant to negotiation as described in Section A.5 of Chapter VIII. ~~reimbursed pursuant to Chapter II.~~
5. Services provided by a large public hospital, as described in Chapter XXX ~~Chapter XIII and XIV~~.
6. Hospital residing long term care services, as described in Chapter XI.
7. Sub-acute alcoholism and substance abuse treatment services, as defined in Section P. of Chapter VIII. ~~Appendix to Attachment 3.1-A, Item 13.d.~~

8) Inpatient services provided by Children's Specialty Hospitals as described in Chapter VIII.

9) Non-transplant i~~I~~npatient services provided by non-cost reporting hospitals, which will be reimbursed at a rate of $672.24 per day or the provider's per diem rate in effect on June 30, 2014.

~~10/92~~ ~~B. Excluded and Exempted Hospitals and Hospital Units: General Rules~~

~~1. Criteria~~

~~10/92~~ ~~A hospital will be excluded from the DRG PPS if it meets the criteria for one or more of the classifications described in Section C. of this Chapter.~~

~~09/91~~ ~~2. Alternate Reimbursement System~~

~~All excluded hospitals (and excluded distinct part hospital units, as described in Section D. of this Chapter) are reimbursed under the Alternate Reimbursement Systems set forth in Chapter VIII, with the exception of county-owned hospitals in a county of over 3 million in population which are reimbursed under the methodology set forth in Chapter XIII, and state-owned hospitals in a county of over 3 million in population which are reimbursed under the methodology set forth in Chapter XIV.~~

07/14 ~~09/91~~ C. Excluded Hospitals: Classifications Prior to July 1, 2014

Hospitals that meet the requirements for the classifications set forth in this Section may not be reimbursed under the DRG Prospective Payment System.

1. Psychiatric Hospitals

   A psychiatric hospital must:

   a. Be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons; and

8. County-Owned Hospitals and Hospitals Organized Under the University of Illinois Hospital Act

   County-owned hospitals located in an Illinois county with a population greater than three million and hospitals organized under the University of Illinois Hospital Act are excluded from the DRG PPS and are reimbursed under unique hospital-specific reimbursement methodologies as described in Chapters XIII and XIV.

~~D. Excluded Distinct Part Hospital Units~~

~~1. Distinct Part Psychiatric Units~~
~~With the exception of those hospitals described in Sections C.1 through C.8 of this Chapter, a hospital enrolled with the Department to provide inpatient psychiatric services (category of service 21) shall be excluded from the DRG PPS for the reimbursement of such inpatient psychiatric services and shall be reimbursed in accordance with Chapter VIII.~~

~~2. Distinct Part Rehabilitation Units~~
~~With the exception of those hospitals described in Sections C.1 through C.8 of this Chapter, a hospital enrolled with the Department to provide inpatient rehabilitation services (category of service 22) shall be excluded from the DRG PPS for the reimbursement of such inpatient rehabilitation services and shall be reimbursed in accordance with Chapter VIII.~~

01/13 III. Conditions for Payment Under the Prospective Payment System

09/91 A. General Requirements

1. A hospital must meet the conditions of this Chapter to receive payment under the DRG PPS for inpatient hospital services furnished to persons receiving coverage under the Medicaid Program.

2. If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicaid-clients, the Department may, as appropriate:

   a. Withhold Medicaid payment (in full or in part) to the hospital until the hospital provides adequate assurances of compliance; or

   b. Terminate the hospital's Provider Agreement.

09/91 B. Hospital Utilization Control

07/14 ~~10/92~~ Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 2013~~1991~~). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Chapter VII ~~Chapter II.C.1~~,shall be in accordance with Federal regulations at 42 CFR, CH. IV, Part 456, Subpart G (October 1, 2013~~1991~~).

01/13 3. A determination under Section F.1 of this Chapter, if it is related to a pattern of inappropriate admissions, length of stay and billing practices that has the effect of circumventing the prospective payment system, may result in actions specified in Section A.2 of this Chapter.

01/13 4. Adjustments for Potentially Preventable Readmissions

For claims received on or after January 1, 2013, rates of payment to hospitals that have an excess number of potentially preventable readmissions as defined in accordance with the criteria set forth in this subsection, as determined by a risk adjusted comparison of the actual and targeted number of readmissions in a hospital as described below, shall be reduced as described below.

a. Potentially Preventable Readmission (PPR) Criteria.

i. A potentially preventable readmission is defined as an inpatient readmission within 30 days of discharge that is clinically related to the initial admission, as defined by the Potentially Preventable Readmission (PPR) software created and maintained by the 3M Corporation, and meets all of the following criteria:

A. The readmission is potentially preventable by the provision of appropriate care consistent with accepted standards, based on the 3M software, in the prior discharge or during the post discharge follow-up period.

B. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge.

C. The readmission is to the same or to any other hospital.

ii. Admissions data, for the purposes of determining PPRs, excludes the following circumstances:

A. The discharge was a patient initiated discharge and was against medical advice and the circumstances of such discharge and readmission are documented in the patient's medical record.

B. The admission was for the purpose of securing treatment for a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions, HIV, alcohol or drug detoxification, non-acute events (rehabilitation admissions), or for hospitals defined in Chapter VII ~~Chapter H.C.4~~, with an APR DRG code other than 740 through 760.

C. The admission was for an individual who was dually eligible for Medicare and Medicaid, or was enrolled in a Medicaid Managed Care Entity (MCE)~~Managed Care Organization (MCO).~~

07/13 D. Effective for state fiscal year 2014 and each year thereafter, admissions for children defined as less than the age of 19 that have a primary diagnosis at discharge for behavioral health. Children treated for an acute service, but have a secondary diagnosis of behavioral health are still included in the analysis, but the Pediatric/Behavioral Health Factor is applied.

category the three factor calculations include a primary diagnosis of non-behavioral health with no presence of behavioral health, a primary diagnosis of non-behavioral health with a secondary diagnosis of behavioral health and a primary diagnosis of behavioral health.

"Base Year" means state fiscal year 2010 and it is the initial data year the department used to calculate the statewide average PPR rate. Each hospital's Current Year is compared to the Base Year to measure the hospital's PPR performance over time.

"Current Year" means the state fiscal year in which targeted rate of readmission is set for hospitals to achieve their targeted rates of readmission.

"Data Year" means the most recent fully adjudicated claims data in a state fiscal year available to the department which is used to calculate the actual rate of readmission and the targeted rate of readmission for each hospital.

G. Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

07/14 1. The ~~applicable~~ payments made under the PPS are payment in full for all inpatient hospital services other than for the services of non-hospital-based physicians to individual program participants and the services of certain hospital-based physicians whose salary is not included in the hospital's cost report. ~~as described in Sections G.1.b.i.through G.1.b.v. of this Chapter.~~

[MATERIAL REMOVED]

~~a. Hospital-based physicians who may not bill separately on a fee-for-service basis~~

~~i. A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.~~

~~ii. A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.~~

~~b. Hospital-based physicians who may bill separately on a fee-for-service basis~~

~~i. A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.~~

~~ii. A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.~~

~~iii. A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.~~

~~iv. A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.~~

~~v. A physician holding a non-teaching administrative or staff position in a hospital or medical school but only may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.~~

2. Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

07/14 IV. Basic Methodology for Determining DRG PPS Prospective Payment Rates Prior to July 1, 2014

09/91 A. DRG Classification and Weighting Factors

1. DRG Classification

10/93 The Department will utilize the DRG Grouper, as described in Section B.5 of Chapter XV., to classify inpatient hospital discharges by diagnosis related groups (DRG's) as defined by federal regulation for the Medicare Program (42 CFR 412) with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

2. DRG Weighting Factors

3. Application of Upper Payment Limits

   The Department shall adjust each of the prospective payment rates determined under Sections B.1 and B.2 of this Chapter (with the exception of disproportionate share payment adjustments made in accordance with Chapter VI.C.7.) To ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42CFR 447.272, Application of Upper Payment Limits.

07/14 C. Notwithstanding the provisions set forth in Chapter IV, effective January 1, 2001, payments for hospital inpatient services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals described in Chapter VII ~~Chapter II.C8~~, or children's hospitals described in Chapter VII ~~Chapter II.C. 3~~. This payment limitation shall not apply to or affect disproportionate share payments as described in Chapter VI.C.7, payments for outlier costs as described in Chapter V., or for payments for Medicaid High Volume Adjustments as described in Chapter VI.J.

~~V. Payment For Outlier Cases~~

~~09/91~~ ~~A. General Provisions~~

~~10/93~~ ~~1. Except as provided in Sections A.2 and A.3, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following Sections A.1.a or A.1.b apply:~~

~~10/93~~ ~~a. The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.~~

~~10/93~~ ~~i. For the rate period described in Section B.2.a of Chapter XV, the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three standard deviations.~~

IV. Methodology for Determining DRG Prospective Payment Rates Effective July 1, 2014

A-1. Inpatient hospital services that are not excluded from the DRG PPS pursuant to Chapter II. shall be reimbursed as determined in this Section.

B-1. Total DRG PPS payment. Under the DRG PPS, services to inpatient who are:

1. Discharges shall be paid pursuant to subsection (c).

2. Transfers shall be paid pursuant to subsection (g)

3. The total payment for an inpatient stay will equal the sum of the payment determined in subsection (c) or (g), as applicable, and any applicable adjustments to payment specified in this Attachment. ~~89 Ill. Adm. Code 148.290.~~

C-1. DRG PPS payment for discharges. The reimbursement to hospitals for inpatient services based on discharges shall be the product, rounded to the nearest hundredth, of the following:

1. The greater of:

   a. 1.0000, or

   b. highest policy adjustment factor, as defined in subsection (f), for which the inpatient stay qualifies.

2. The sum of the DRG base payment, as defined in subsection (d), and any applicable outlier adjustment, as determined in Chapter V for which the claim qualifies.

D-1. The DRG base payment for a claim shall be the product, rounded to the nearest hundredth, of:

1. The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper.

2. The DRG base rate, equal to the sum of:

   A. The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare IPPS wage index, the statewide standardized amount and the GME factor.

   B. The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the statewide standardized amount and the GME factor.

E-1. Medicare IPPS wage index. Medicare IPPS wage index is determined based on:

1. For Medicare IPPS hospitals that are in-state or are out-of-state Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system hospital post-re-class wage index effective October 1, 2012.

2. For in-state non-Medicare IPPS hospitals and out-of-state non-Medicaid cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective October 1, 2012. ~~For non-Medicare IPPS hospitals and non-cost reporting hospitals, the wage index is based on the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system wage index for the hospital's Medicare CBSA effective October 1, 2012.~~

F-1. Policy adjustments. Claims for inpatient stays that meet certain criteria may qualify for further adjustments to payment.

1. Transplantation services.

   a. Policy adjustment factor: 2.11.

   b. Qualifying criteria.

      i. The hospital meets all requirements to perform transplantation services and is certified as a transplant center. ~~, including but not limited to those detailed in 89 Ill. Adm. Code 148.82.~~

      ii. The claim has been grouped to one of the following DRGs:

      001 Liver transplant.

      002 Heart and/or lung transplant.

      003 Bone marrow transplant.

      006 Pancreas transplant.

      440 Kidney transplant.

2. Trauma services.

a. Policy adjustment factor:

i) 2.9100, if the hospital is a level I trauma center.

ii) 2.7600, if the hospital is a level II trauma center.

b. Criteria:

i. Hospital is recognized by the Department of Public Health as a level I or II trauma center on the date of admission.

ii.. The claim has been grouped to one of the following DRGs:

020 Craniotomy for trauma

055 Head trauma, with coma lasting more than on one hour or no coma.

056 Brain contusion/laceration and complicated skull fracture, coma less than one hour or no coma.

057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.

135 Major chest and respiratory trauma.

308 Hip and femur procedures for trauma, except joint replacement.

384 Contusion, open wound and other trauma to skin and subcutaneous tissue.

910 Craniotomy for multiple significant trauma.

911 Extensive abdominal/thoracic procedures for multiples significant trauma.

912 Musculoskeletal and other procedures for multiple significant trauma.

930 Multiple significant trauma, without operating room procedure.

3.~~iii.~~Perinatal services.

a. Policy adjustment factor:

i. 1.3500, if the DRG to which the claim is grouped has an SOI of 1.

ii. 1.4300, if the DRG to which the claim is group has an SOI of 2.

iii. 1.4100, if the DRG to which the claim is grouped has an SOI of 3.

iv. 1.5400, if the DRG to which the claim is grouped has an SOI of 4.

b. Criteria:

i. Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission.

ii. The claim has been grouped to one of the following MDCs:

14 Pregnancy, childbirth and puerperium

15 Newborn and other neonates.

4. Safety Net

a. Policy adjustment factor: $57.50 per general acute care day.

b. Qualifying criteria: ~~safety-net hospital defined in 305 ILCS 5/5-5e.1 excluding pediatric hospitals as defined in Chapter II.C.3.~~ Hospital is a safety-net hospital, excluding pediatric hospitals as defined in Chapter II.C.3. A safety net hospital is defined as a hospital:

i. Licensed by the Department of Public Health as a general acute care or pediatric hospital.

ii. Is a disproportionate share hospital.

iii. Meets one of the following:

A. has a MIUR of at least 40% and a charity percent of at least 4%; or

B. has a MIUR of at least 50%.

c. Effective for dates of service on or after July 1, 2014.

G-1. DRG PPS payment for transfers. The reimbursement to hospitals for inpatient services provided to transfers shall be lesser or:

1. The amount that would have been paid pursuant to subsection C-1 had the inpatient been a discharge.

2. The product, rounded to the nearest hundredth, of the following:

a. The quotient resulting from dividing the amount that would have been paid pursuant to subsection C-1, had the inpatient been a discharge by the DRG average length of stay for the DRG to which the inpatient claim has been assigned.

b The length of stay plus the constant 1.0.

H-1. Updates to DRG PPS reimbursement. The Department may annually review the components as listed in subsection (c) and make adjustments as needed. Grouper shall be updated at least triennially and no more frequently than annually.

I-1. Definitions.

"Allocated static payments" means the State plan approved adjustment payments in Chapter XV effective during State fiscal year 2011, excluding those payments that continue after July 1, 2014 ~~made to the hospital pursuant to 89 Ill. Adm. Code 148.85 through 148.117 and 148.295 through 148.297 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in: http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department~~, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Discharge" means a hospital inpatient that (i) has been formally released from the hospital, except when the patient is a transfer or (ii) died in the hospital.

"DRG" means diagnosis related group, as defined in the DRG grouper, based the principal diagnosis, surgical procedure used, age of patient, etc.

"DRG average length of stay" means, for each DRG and SOI combination, the national arithmetic mean length of stay for that combination rounded to the nearest tenth, as published by 3M Health Information Systems for the DRG grouper.

"DRG grouper" means the most recently released version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, DRG grouper means the version 30 of the APR-DRG software.

"DRG PPS" means the DRG prospective payment system as described in this Attachment.

"DRG weighting factor" means, for each DRG and SOI combination shall equal the product, rounded to the nearest ten-thousandth, of the national weighting factor for that combination, as published by 3M Health Information Systems for the DRG grouper, and the Illinois experience adjustment.

"GME factor" means the Graduate Medical Education factor applied to major teaching hospitals as defined in Chapter XVIII ~~148.25(h)~~ determined such that simulated payments under the new inpatient system with GME factor adjustments are $3 million greater than simulated payments under the new inpatient system without GME factor adjustments, using inpatient base period paid claims data.

"Illinois experience adjustment" means for the calendar year beginning January 1, 2014, a quotient, computed by dividing the constant 1.0000 by the arithmetic mean 3M APR-DRG national weighting factors of claims for inpatient stays subject to reimbursement under the DRG PPS using inpatient base period paid claims data, rounded to the nearest ten-thousandth; for subsequent calendar years, means the factor applied to 3M APR-DRG national weighting factors, when updating DRG grouper versions determined such that the arithmetic mean DRG weighting factor under the new DRG grouper version is equal to the arithmetic mean DRG weighting factor under the prior DRG grouper version using inpatient base period claims data.

"Inpatient base period claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for DRG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12 months of inpatient paid claims data to be identified by the Department.

"Inpatient stay" means a formal admission into a hospital, pursuant to the order of a licensed practitioner permitted by the state in which the hospital is located to admit patients to a hospital that requires at least one overnight stay.

"Length of stay" means the number of days the patient was an inpatient in the hospital; with the day of the patient became a discharge or transfer not counting toward the length of stay.

"Medical assistance" means one of the programs administered by the Department that provides health care coverage to Illinois residents.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

"Medicare IPPS labor share percentage" means the Medicare inpatient prospective payment system operating standardized amount labor share percentage for the federal fiscal year ending three months prior to the calendar year during which the discharge occurred; except, for the calendar year beginning January 1, 2014, the labor share percentage in the Medicare inpatient prospective payment system for the federal fiscal year beginning October 1, 2012, which is 0.6880 for a hospital with a Medicare IPPS wage index greater 1.0 or 0.6200 for all other hospitals.

"Medicare IPPS non-labor share" means the difference of 1.0 and the Medicare IPPS labor share percentage.

"MDC" means major diagnostic category – group of similar DRGs, such as all those affecting a given organ system of the body.

"SOI" means one of four subclasses of each DRG, as published by 3M Health Information Systems for the DRG grouper that relate to severity of illness (the extent of physiologic de-compensation or organ system loss of function experience by the patient) and risk of (the likelihood of) dying.

"Statewide standardized amount" means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS payments, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period paid claims data, are $355 million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

"Transfer" means a hospital inpatient that has been placed in the care of another hospital except that a transfer does not include an inpatient claim that has been assigned to DRG 580 (Neonate, transferred, less than five days old, not born here) or 581 (Neonate, transferred, less than five days old, born here).

[MATERIAL REMOVED]

~~07/95~~ ~~ii. For rate periods described in Section B.2.b. of Chapter XVI, the Department shall utilize the geometric mean length of stay plus the lesser of three standard deviations, or the Medicare day outlier cutoff threshold in effect 90 days prior to the date of admission, adjusted by a factor, the numerator of which is the Medicaid geometric length of stay, and the denominator of which is the average Medicare geometric mean length of stay.~~

~~10/93~~ ~~b. .The hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio as described in Section C.3 of this Chapter, exceed the greater of:~~

~~07/95~~ ~~i. For the rate period described in Section B.2.a.of Chapter XVI, $34,000 as adjusted for the hospital's labor market, or the hospital's DRG-PPS base rate as described in Section B.2.a of Chapter IV multiplied by two.~~

~~07/95~~ ~~ii. For the rate periods described in Section B.2.b. of Chapter XVI, the Department shall utilize the Medicare established cost outlier cutoff threshold in effect 90 days prior to the date of admission.~~

~~10/93~~ ~~2. The Department will provide cost outlier payments to a transferring hospital reimbursed under the DRG PPS that does not receive payment under Section B. of this Chapter, for discharges specified in Section D.4.b. of Chapter I., if the hospital's charges for covered services furnished to the client, adjusted to cost by applying a cost-to-charge ratio as described in Section C.3 of this Chapter, exceed:~~

[MATERIAL REMOVED]

~~10/93~~ ~~a. For the rate period described in Section B.2.a.of Chapter XV, the greater of the criteria specified in Section A.1.b.i.of this Chapter.~~

~~10/93~~ ~~b. For the rate periods described in Section B.2.b of Chapter XV, the criteria specified in Section A.1.b.ii of this Chapter.~~

~~10/93~~ ~~3. The Department will not provide outlier payments for:~~

~~10/93~~ ~~a. Discharges classified as psychiatric care (DRG's 424-432). Such care provided by other than hospitals or distinct part units enrolled with the Department to provide psychiatric care (category of service 21) is limited to emergency treatment, to last no longer than three days.~~

~~10/93~~ ~~b. Discharges assigned to DRG's with an Illinois weighting factor of zero (0.0000).~~

~~10/93~~ ~~4. The Department or its designee may review outlier cases on a prepayment or post-payment review basis. The charges for any services identified as non-covered through this review will be denied and any outlier payment having been made for those services will be recovered, as appropriate, after a determination as to the provider's liability has been made. If the Department or its designee finds a pattern of inappropriate utilization by a hospital, all outlier cases from that hospital are subject to medical review, and this review may be conducted prior to payment until the Department or its designee determines that appropriate corrective actions have been taken. The Department, or its designee, must review and approve, to the extent required by the Department:~~

[MATERIAL REMOVED]

~~a. The admission was medically necessary and appropriate.~~

~~b. The medical necessity and appropriateness of the admission and outlier services in the context of the entire stay.~~

~~c. The services were ordered by the physician, actually furnished, and nonduplicatively billed.~~

~~d. The validity of the diagnostic and procedural coding.~~

~~e. The granting of up to three administrative (grace) days during which the hospital is seeking an appropriate setting into which to discharge a non-acute patient~~

~~09/91~~ ~~B. Payment for Extended Length-of-Stay Cases (Day Outliers)~~

~~10/92~~ ~~1. If the hospital stay includes covered days of care beyond the applicable threshold criterion, the Department will make an additional payment, on a per diem basis, to the discharging hospital for those days and the transferring hospital for DRG's 385, 456, or 985 only. A special request or submission is not necessary to initiate this payment.~~

~~07/95~~ ~~2. .Except as provided in Section D. of this Chapter, and subject to the limitations described in Section E. of this Chapter, the per diem payment made under Section B.1 of this Chapter, is derived by first taking the marginal cost factor, as defined in Section B.8, of Chapter XVI, of the per diem payment for the applicable DRG, as calculated by dividing the DRG PPS base rate, determined under Section B.2.c. of Chapter IV by the mean length-of-stay for that DRG.~~

[MATERIAL REMOVED]

~~10/93~~ ~~3. Any days in a covered stay identified as non-covered reduce the number of days reimbursed at the day outlier rate but not to exceed the number of days that occur after the day outlier threshold.~~

~~09/91~~ ~~C. Payment for Extraordinarily High Cost Cases (Cost Outliers)~~

~~10/92~~ ~~1. If the hospital charges, as adjusted by the method specified in Section C.3 of this Chapter, exceed the applicable threshold criterion, the Department will make an additional payment to the hospital to cover those costs. A special request or submission is not necessary to initiate this payment.~~

~~10/93~~ ~~2. The Department will reimburse the cost of the discharge on the billed charges for covered inpatient services, adjusted by a cost-to-charge ratio as described in Section C.3.of this Chapter, subject to the limitations described in Sections C.4 and E. of this Chapter.~~

~~10/93~~ ~~3. The cost-to-charge ratio used to adjust covered charges is computed at the eginning of each rate period, as described in Section B.2 of Chapter XV, by the Department for each hospital based on the hospital's base fiscal year. Statewide cost-to-charge ratios are used in those instances in which a hospital's cost-to-charge ratio falls outside reasonable parameters or cannot be computed due to a lack of information (e.g., a new hospital for which the Department is not in possession of the required historical information).~~

[MATERIAL REMOVED]

4. If any of the services are determined to be non-covered, the charges for those services will be deducted from the requested amount of reimbursement but not to exceed the amount claimed above the cost outlier threshold.

07/95 5. For the rate periods described in Section B.2.of Chapter XVI, the Department shall employ the same methodologies and rates used by Medicare, to calculate additional payments for cost outliers.

09/91 D. Payment for Extraordinarily High Cost Day Outliers

If a discharge qualifies for an additional payment under the provisions of both Sections B. and C. of this Chapter, the additional payment is the greater of the following:

1. The payment computed under Section B. of this Chapter.

2. The payment computed under Section C. of this Chapter.

10/93 E. Outlier Payment Limitation. Notwithstanding any other provisions of this Chapter, the total reimbursement paid by the Department for a claim qualifying for an outlier payment under this Chapter shall not exceed the total covered inpatient charges.

07/05 F. Notwithstanding the provisions of this Chapter, payment for outlier cases shall be determined by using the following factors that were in effect on June 30, 1995:

1. The marginal cost factor (see Chapter XVI (B)(7)),

2. The Metropolitan Statistical Area (MSA) wage index (see Chapter VI(C)(2)),

3. The Indirect Medical Education (IME) factor (see Chapter VIII A 2(a)(i)(B)(4),

4. The cost to charge ratio (see Chapter V(C)(3), and

5. The cost outlier threshold, (see Chapter XVI (B)(8)) where

a. For admissions on or after December 3, 2001 through June 30, 2005, the cost outlier threshold multiplied by 1.22.

01/08 b. For admission on of after July 1, 2005, through December 31, 2007, the cost outlier threshold multiplied by 1.40.

01/11 c. For admission on or after January 1, 2008, through December 31, 2010, the cost outlier multiplied by 1.64.

01/11 d. For admissions on or after January 1, 2011, the cost outlier threshold multiplied by 1.99.

V. Payment For Outlier Cases

A. Outlier adjustment determination. Except as provided in subsection B., the Department will ~~may~~ provide for additional payment, approximating a hospital's marginal cost of covered inpatient hospital services beyond thresholds specified by the Department. To qualify for such payment, the claim must meet the following criteria:

1. The services on the claim must be reimbursable under the DRG PPS.

2. The DRG grouper must be able to assign the claim to a DRG

3. The estimated claim cost for a claim exceeds the claim outlier threshold for the DRG to which the claim has been assigned

B. Estimated claim cost. Estimated claim cost is based on the product of the claim total covered charges and the hospital's Medicare IPPS outlier cost-to-charge ratio. The Medicare IPPS outlier cost-to-charge ratio is determined based on:

1. For Medicare IPPS hospitals, the outlier cost-to-charge ratio is based on the sum of the Medicare inpatient prospective payment system hospital-specific operating and capital outlier cost-to-charge ratios effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

2. For non-Medicare IPPS hospitals ~~and non-cost reporting hospitals located in an urban Medicare CSBA~~, the outlier cost-to-charge ratio is based on the sum of the Medicate inpatient prospective payment system statewide average operating and capital outlier cost-to-charge ratios for urban hospitals for the state in which the hospital is located, effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

C. Exclusions. No outlier adjustment shall be paid on claims that are excluded from the DRG PPS pursuant to Chapter II.B.~~:~~

~~1. Inpatient psychiatric, rehabilitation and long-term acute care services excluded from the DRG PPS pursuant to Chapter II~~

~~2. Claims for which Medicare is the primary payer~~

D. Outlier adjustment payment. The amount of the additional payment shall be determined as the product, rounded to the nearest hundredth, of:

1. the difference resulting from subtracting the claim outlier threshold from the estimated claim cost, and
2. the applicable Severity of Illness (SOI) adjustment factor, rounded to the nearest hundredth.

E. Definitions.

In addition to terms elsewhere defined in this subchapter, terms relating to outlier adjustments are defined as follows:

"Claim outlier threshold" means the sum of the DRG base payment, as defined in Chapter IV.C-1.2. and the fixed loss threshold.

Fixed loss threshold" means the Medicare fixed loss threshold in effect on October 1, 2012. The Department is authorized to update the "fixed loss threshold." Base rates must be updated within 12 months of this update.

~~"Fixed loss threshold" means the Medicare fixed loss threshold in effect on the first day of October preceding the calendar year during which the inpatient discharge occurred; except for calendar year 2014, it means the Medicare fixed loss threshold in effect on October 1, 2012.~~

"MDC" means major diagnostic category.

"Medicare CBSA" means the Core-Based Statistical Areas for a hospital's location effective in the Medicare inpatient prospective payment system at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred.

"Severity of Illness (SOI) adjustment factor" means for SOI 1, 0.8000; for SOI 2, 0.8000; for SOI 3, 0.9500; for SOI 4, 0.9500.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMS 1450), or one of its electronic transaction equivalents.

VI. Special Treatment of Certain Facilities

09/91 A. General Rules

07/14~~09/91~~ ~~1. Sole Community Hospitals~~ Reserved.

~~10/93~~ ~~Hospitals defined as sole community hospitals under Section B. of this Chapter, shall have the choice of being reimbursed under the DRG-PPS methodology, as described in Chapters I. through VII, or the Department's Alternate Reimbursement methodology as described in Chapter VIII, in accordance with the provisions of Sections H. through J. of Chapter VIII.~~

10/92 2. Hospitals that Serve a Disproportionate Share of Low Income Patients

10/93 The Department shall make additional payments to hospitals that serve a disproportionate share of low- income patients. The criteria and methodologies for such additional payments are set forth in Section C. of this Chapter.

07/95 3. Specific Inpatient Payment Adjustments

The Department shall make specific additional payments to applicable hospitals as set forth in this Attachment. ~~Sections E. through F. of this Chapter and Chapter XV.~~

07/14~~09/91~~ B. Special Treatment: Sole Community Hospitals Prior to July 1, 2014

1. Criteria for Classification as a Sole Community Hospital.

"Medicaid Sole Community Provider" means a hospital that meets one of the following criteria:

10/93 a. Medicare Program Designation

10/93 i. For the rate period described in Section B.2.a.of Chapter XV, any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective September 1, 1992.

ii. For the rate period described in Section B.2.b.of Chapter XV, any hospital designated as a "sole community provider" by the U.S. Department of Health and Human Services for purposes of reimbursement under the federal Medicare Program effective 90 days prior to the date of admission.

07/91 C. Special Treatment: Hospitals That Serve a Disproportionate Share of Low Income Patients

10/03 1. Qualified Disproportionate Share Hospitals (DSH)

Disproportionate Share (DSH) adjustments~~, for inpatient services provided prior to October 1, 2003, shall be determined and paid in accordance with State plans governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 2003, and each October 1, thereafter, unless otherwise noted. For inpatient services provided on or after October 1, 2003, the~~ The Department shall make adjustment payments to hospitals, which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

10/03 a. The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section C.8.d, is at least one standard deviation above the mean Medicaid inpatient utilization rate, as defined in Section C.8.c.

03/95 b. The hospital's low-income utilization rate exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children, Transitional and Interim Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children, Transitional, and Interim Assistance (formerly known as General Assistance), AMI inpatient hospital services, and/or any local or state government-funded care) must be added.~~

[MATERIAL REMOVED]

~~10/92~~ ~~2. In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in Sections C.1 throughC.4 of Chapter II, must submit a statement to that effect.~~

10/10

2. In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in Sections B.1. through B.3. and B.8. ~~C.1 through C.4~~ of Chapter II, must submit a statement to that effect. "Obstetric services" shall at minimum include non-emergency inpatient deliveries in the hospital.

10/92

3. In making the determination described in Sections C.1.a ~~and C.1.d.~~ of this Chapter, the Department shall utilize:

   a. Hospital Cost Report

      i. The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in Section C.8.e of this Chapter, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Chapter IX, with the exception of errors in calculation.

      ii. In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's un-audited cost report for the hospital's base fiscal year. Due to the un-audited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in Sections C.1.a ~~and C.1.d.~~ of this Chapter. Submittal of a corrected cost report in support of Sections C.1.a ~~and C.1.d.~~ of this Chapter must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification. Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's ~~Medicaid inpatient utilization rate~~ MIURas described in Section C.8.ce of this Chapter.

      iii. Hospitals' Medicaid inpatient utilization rates, as defined in subsection 8.d.e. of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Chapter IX ~~Section 148.310~~, with the exception of errors in calculation. Pursuant to subsection 3.a.ii. ~~(3)(a)(ii)~~, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination. ~~In the event of extensions to the Medicare cost report filing process, those hospitals that do not have an audited or un-audited base year Medicaid cost report on file with the Department by the 30th of April preceding the DSH determination are required to complete and submit to the Department a Hospital Day Statistics Collection (HDSC) form. On the form, hospitals must provide total Medicaid days and total hospital days for the hospital's base fiscal year. The HDSC form must be submitted to the Department by the April 30th preceding the DSH determination.~~

[MATERIAL REMOVED]

~~A) If the Medicare deadline for submitting base fiscal year cost reports falls within the month of June preceding the DSH determination, hospitals, regardless of their base fiscal year end date, will have until the first day of August preceding the DSH determination to submit changes to their Medicaid cost reports for inclusion in the final DSH calculations. In this case, the HDSC form will not be used as a data source for the final rate year DSH determination~~

~~B) If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be used in the final DSH determination for all hospitals that do not have an audited or un-audited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30th.~~

~~iv. Hospitals' Medicaid inpatient utilization rates, as defined in Section C.8.d of this Chapter, which have been derived from un-audited cost reports or the HDSC form, are not subject to the Review Procedure described in Chapter IX, with the exception of errors in calculation. Pursuant to Sections C3 a .ii and C.3.c.iii.B) of this Chapter, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.~~

[MATERIAL REMOVED]

~~B) If the Medicare deadline for submitting base fiscal year cost reports is extended beyond the month of June preceding the DSH determination, the HDSC form will be used in the final DSH determination for all hospitals that do not have an audited or un-audited Medicaid cost report on file with the Department. Hospitals will have until the first day of July to submit any adjustments to the information provided on the HDSC form sent to the Department on April 30th.~~

~~iv. Hospitals' Medicaid inpatient utilization rates, as defined in Section C.8.e of this Chapter, which have been derived from un-audited cost reports or the HDSC form, are not subject to the Review Procedure described in Chapter IX, with the exception of errors in calculation. Pursuant to Sections C3 a .ii and C.3.e.iii.B) of this Chapter, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH determination.~~

~~v. In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in Section C.8.e of this Chapter, which is lower than the Medicaid inpatient utilization rate derived from the un-audited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.~~

iv~~v~~. In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in Section C.8.d. of this Chapter, which is lower than the MIUR derived from the un-audited cost report or the HDSC form utilized for the DSH determination, the Department shall recalculate the MIUR based upon the final audited cost report, and recoup any overpayments made.

b. Days Not Available from Cost Report

Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, *i.e.*, Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid managed care entity (MCE) ~~Managed Care Organization (MCO)~~ days, hospital residing long term care days, and Medicaid days for Alcohol and Substance Abuse (ASA) sub-acute~~rehabilitative~~ care. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

i. Medicare/Medicaid Crossover Claims.

A) The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year.

~~For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the remainder of Section C.3.c.i of Chapter VI will not be used in the determination process for DSH determination years on or after October 1, 1996.~~

~~B) For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days, which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.~~

10/92

ii. Out-of-State Title XIX Utilization Levels Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

iii. MCE~~MCO~~ Days. The Department will utilize the Department's MCE~~MCO~~ claims data available to the Department as of the last day of June preceding the DSH determination year, or specific claim information from each MCE~~MCO~~ for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an MCE~~MCO~~.

10/93

iv. Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care days provided to recipients.

07/95

v. Alcohol and Substance Abuse (ASA) Days. The Department will utilize the Department's ASA paid claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient ASA days provided 07/954.

4. Hospitals may apply for DSH status under Section C.1.b. of this Chapter, by submitting an audited certified financial statement for the hospital's base fiscal year ~~to the Department.~~ ~~The Department of Mental Health and Developmental Disabilities must submit a statement, signed by the Director of that agency, certifying the accuracy of the data submitted for the facilities operated by that agency~~ to the Department of Human Services or the Department of ~~Public Aid~~Healthcare and Family Services. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:

10/92 a. Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospitals' base fiscal year.

10/92 b. Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospitals' base fiscal year.

10/93

c. Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts, ~~except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, and AMI patients),~~ for the hospital's base fiscal year.

10/92

d. Total of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

07/95

5. With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the State in which they are located based upon the Federal definition of a DSH hospital, as defined in (42 U.S.C. 1396r-4[b][1]), ~~Section 1923(b)(1) of the Social Security Act~~, may qualify for DSH hospital adjustments under Sections C.7.a and C.7.b. of this Chapter. For purposes of determining the Medicaid inpatient utilization rate, as described in Section C.8.e and as required in (42 U.S.C. 1396r-4[b][1]), ~~Section 1923(b)(1) of the Social Security Act~~, out-of-state hospitals will be measured in relationship to one standard deviation above the mean MIUR ~~Medicaid inpatient utilization rate~~ in their state. Out-of-state hospitals that do not qualify by the MIUR ~~Medicaid inpatient utilization rate~~ from their state may submit an audited certified financial statement as described in Section C.4. Payments to out-of-state hospitals will be allocated using the same methods as described in Section C.7.

10/92 6. Time Limitation Requirements for Additional Information

a. Unless specifically stated otherwise in the applicable administrative rule, the information required in Sections C.1, C.3, C.4, and C.5, must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this Chapter, which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

04/09 b. The information required in Section C.2 must be submitted after ~~received within 30 calendar days of~~ receipt of notification from the Department ~~that the information must be submitted.~~ Information required in this section, that is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

10/92 7. Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by Section C.1 of this Chapter shall be calculated annually as follows:

04/09 a. Five Million Dollar Fund Adjustment for Hospitals Defined in Chapter XV, Sections A.1 and A.2, with the exception of any Illinois hospital that is owned or operated by the State or a unit of local government.

10/93 i. Hospitals qualifying as DSH hospitals under Section C.1.a, or ~~that have a Medicaid inpatient utilization rate, as described in Section C.8.e, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in Section C.8.e., and hospitals qualifying as DSH hospitals under~~ Section C.1.b. of this Chapter will receive an add-on payment to their inpatient rate.

10/93

ii. The distribution method for the add-on payment described in Section C.7.a.i above is based upon a fund of $5 million. All hospitals qualifying under Section C.7.a.i.above will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

10/93

iii. The remaining fund balance is then distributed to the hospitals that qualify under Section C.1.a of this Chapter ~~that have a Medicaid inpatient utilization rate, as described in Section C.8.e, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in Section C.8.c.,~~ in proportion to the percentage by which the hospital's MIUR ~~Medicaid inpatient utilization rate~~ exceeds one standard deviation above the State's mean MIUR ~~Medicaid inpatient utilization rate~~, as described in Section C.8.c. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospitals proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

10/93

iv. The total dollar amount calculated for each qualifying hospital under Section C.7.a.iii, (plus the initial $5 per day add-on amount calculated for each qualifying hospital under Section C.7.a.ii.,) is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at per day add-on value. Hospitals qualifying under Section C.1.b. of this Chapter will receive the minimum adjustment of $5 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in Section C.7.g. of this Chapter. The adjustments calculated under Section 7 shall be paid on a per diem basis and shall be applied to each covered day of care provided.

10/00 c. Department of Human Services (DHS) State-Operated Facility Adjustment for Hospitals defined in Chapter XVI, Section A.7. Department of Human Services' State-operated facilities qualifying under Section C.1.b., shall receive an ~~adjustment effective for inpatient services on or after March 1, 1995. Effective October 1, 2000, the~~ adjustment payment ~~shall be~~ calculated as follows.

10/03 i. The amount of the adjustment is based on a State DSH Pool. The State DSH pool amount shall be the lesser of the federal DSH allotment for mental health facilities as determined in Ssection 1923(h) of the *Social Security Act*, minus the estimated DSH payments to such facilities that are not operated by the State.~~; or the result of subtracting the estimated DSH payment adjustments made under Sections C.7.a through C.7.e and f. of this Chapter, and Chapter XIV, Section F.2 from the aggregate DSH payment allotment as provided for in section 1923(f) of the *Social Security Act*~~

10/00 ii. The State DSH Pool amount is then allocated to hospitals defined in Chapter XVI, Section A.7.that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of uninsured care costs, from the most recent final cost report, to the sum of all qualifying hospitals' uninsured care costs.

07/95 iii. The adjustment calculated in Section C.7.c.ii.of this Chapter shall meet the limitation described in Section C.7.f.iv. of this Chapter.

10/03 iv. The adjustment calculated pursuant to Section C.8.c.ii. above, for each hospital defined in Chapter XVI, Section A.7. that qualifies for DSH adjustments, is then divided by four to arrive at a quarterly adjustment. This amount is subject to the limitations described in Section C.7.g. of this Chapter. The adjustment described in this Chapter shall be paid on a quarterly basis.

10/03

d. Assistance for Certain Public Hospitals

i. The Department may make an annual payment adjustment to qualifying hospitals in the DSH determination year in accordance with the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000*, Section 701(d).

ii. Hospitals qualifying shall receive an annual payment adjustment that is equal to the product of subsections A) and B) below:

A. A rate amount equal to the amount specified in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Section 701(d)(3)(B), for the DSH determination year, divided first by Illinois' Federal Medical Assistance Percentage, and divided secondly by the sum of the qualified hospitals total Medicaid inpatient days as defined in subsection (8)(i) of this section; and,

B. Each qualified hospital's Medicaid inpatient days as defined in subsection (8)(i) of this section.

iii. The annual payment adjustment calculated under this subsection, for each qualified hospital, will be divided by four and paid on a quarterly basis.

iv. Payment adjustments under subsection (d) shall be made without regard to sections 1923(f) and 1923(g) of the Social Security Act, 42 CFR 447.272, or any standards promulgated by the Department of Health and Human Services pursuant to section 701(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

07/95

e. Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Section C.1.e of this Chapter, the payment adjustment calculated under Section C.7.b. above shall be multiplied by 2.0.

07/08 f. DSH for government-owned or -operated hospitals.

i. The following classes of government-owned or -operated Illinois hospitals shall, subject to the limitations set forth in subsection g of this section, be eligible for disproportionate share hospital adjustment payment:

A. Hospitals defined in paragraph A.1.a.i of Chapter XVI.

07/14 B. Hospitals owned or operated by a unit of local government that is located within Illinois and is not a hospital defined in subparagraph A above.

~~C. Hospitals defined in paragraph A.1.a.ii of Chapter XVI.~~

03/14 ii. The annual amount of the payment shall be the amount computed for the hospital pursuant to subparagraph g.iv.B of this section, adjusted from the midpoint of the cost report period to the mid-point of the rate period using the CMS Hospital Price Index. ~~. For LARGE PUBLIC HOSPITALS, as defined in Chapter XVI, Section A.1.a.i., the adjustment factor will be the average annual growth in each hospital's cost per diem. The average annual growth shall be calculated as follows:~~

~~A. Inpatient average cost per diems are calculated using Medicaid claims data from two sets of fiscal years that are two years apart. Costs are determined in accordance with the methodology in Chapter XXX., Section D.1.~~

~~B. An average annual increase is calculated based on the percentage change in the average inpatient cost per diems over the two year time period.~~

~~C. The fiscal years used to determine the average annual growth will be updated annually. For example, the fiscal year 2011 rate trend factors are based upon cost per diem information from fiscal years 2006 and 2008; while fiscal year 2012 factors will be based upon cost per diem information from fiscal years 2007 and 2009.~~

iii. The annual amount shall be paid to the hospital in monthly installments. ~~That portion of the annual amount not paid pending approval of this State plan amendment (TN 08-06) shall, upon approval, be paid in a single lump sum payment. The annual amount shall be paid to the hospital in twelve equal installments and paid monthly.~~

07/95 g. DSH Adjustment Limitations.

10/10 i. Hospitals that qualify for DSH adjustments under this Chapter shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall

not apply to those hospitals described in Sections B.1. and B.2. ~~C.1. through C.4.~~ of Chapter II, or those hospitals that have not offered non-emergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under Sections C.7.a through C.7.f. shall cease to be effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care. "Obstetric services" shall at minimum include non-emergency inpatient deliveries in the hospital.

10/92

ii. Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Chapter IX., which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Chapter.

07/08

iii. DSH Payment Adjustment. In accordance with *Public Law 102-234*,- If the aggregate DSH payment adjustments calculated under this Chapter do not meet the State's final DSH allotment as determined by the Centers for Medicare and Medicaid Services, DSH payment adjustments calculated under this section shall be adjusted to meet the State DSH allotment. This adjustment shall be applied to satisfy the payments under this section in the follow order:

A. Payments made under subsection C.7.c.

B. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.i.C.

C. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.i.B.

D. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.a.

E. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.i.A.

F. Payments made under subsection C.7.f to hospitals described in subparagraph C.7.f.b.

07/95 iv. *Omnibus Budget Reconciliation Act of 1993* (OBRA '93) Adjustments.

07/08 A. In accordance with *Public Law 103-66*, adjustments to individual hospital's disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance.

07/08 B. The adjustment to hospitals will be computed by determining a hospitals cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan. The cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients, shall be determined and added to the Medicaid shortfall calculated above.

07/08 C. The result shall be compared to the hospitals estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospitals DSH rate per day so that their DSH payments will equal the DSH limit.

04/11 D. Beginning with State Plan Rate Year 2011, DSH payments that exceed documented hospital-specific limits, as determined through the independent certified audit of the State's DSH program that is required in 42CFR455.304, shall be redistributed to hospitals that had DSH payments limited under Section C.7.g.iii. of this Chapter. The redistributed payments will be made to satisfy the amount that each hospital was determined eligible to receive prior to the Section C.7.g.iii. limitation, and will be made to hospitals based upon the order detailed in that section.

03/95 v. Medicaid Inpatient Utilization Rate Limit Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's Medicaid inpatient utilization rate, as defined in Section C.8.de.of this Chapter, is less than one percent.

07/91 8. Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

07/1410/93 a. "Base fiscal year" means, ~~for example,~~ the hospital's fiscal year in the calendar year, 22 months before the beginning of the ~~ending in 2003 for the October 1, 2003, DSH determination year, the hospital's fiscal year ending in 2002 for the October 1, 2004,~~ DSH determination year, *etc.*

10/93 b. "DSH determination year" means the 12-month period beginning on October 1 of the year and ending September 30 of the following year.

c. "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the federal ~~Federal~~ *Social Security Act* (42 *U.S.C.* Sec. 1396a *et seq.*), and the denominator of which is the total number of inpatient days provided by those same hospitals. ~~Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Sections C.3.a and C3b of this Chapter.~~ In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

d. "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal *Social Security Act* (42 *U.S.C.* Sec. 1396a *et seq.*) and the denominator of which is the total number of the hospital's inpatient days in that same period. ~~Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Sections C.3.a and C.3.b of this Chapter.~~ In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

07/14 ~~10/93~~ e. Reserved. ~~"Mean Medicaid Obstetrical Inpatient Utilization Rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in Section C.8.g. below, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal *Social Security Act* (42 *U.S.C.* Sec. 1396a *et seq.*), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i below, for all such hospitals. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims database.~~

07/95 f. "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in a hospital.

07/14

g. "Low income utilization rate" means a fraction, expressed as a percentage that is the sum of:

i. The fraction (expressed as a percentage):

A. the numerator of which is the sum of the total revenues paid the hospital for patient services under Medicaid State plan (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and the amount of the cash subsidies for patient services received directly from State and local governments, and

B. the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

ii. The fraction (expressed as a percentage):

A. the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in subsection (6)(A)(i) of this Section, and

B. the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

~~i. The quotient resulting from dividing:~~

~~A. the sum of the total Medicaid revenues paid the hospital under this Section for patient services and cash subsidies for patient services received directly from State and local governments, by~~

~~B. the total revenues (including the amount of such cash subsidies) of the hospital for patient services.~~

~~ii. The quotient resulting from dividing:~~

~~A. the hospital's charges for inpatient hospital services that are attributable to charity care in a period, (not including contractual allowances and discounts, other than for indigent patients not eligible for Medicaid under an approved State plan) less the portion of any cash subsidies described in subsection (6)(A)(i) reasonably attributable to inpatient hospital services, by~~

~~B. total inpatient charges attributable to charity care.~~

~~g. "Medicaid (Title XIX) obstetrical inpatient days" means, hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the *Social Security Act*, with a Diagnosis Related Group (DRG) of 370 through 375), and specifically excludes Medicare/Medicaid crossover claims.~~

~~10/93~~ ~~h. "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section B.1.of Chapter VIII.~~

~~10/93~~ ~~i. "Total Medicaid (Title XIX) inpatient days", as referred to in Sections C.8.d. and C.8.f. above, means, hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the *Social Security Act*, and specifically excludes Medicare/Medicaid crossover claims.~~

~~10/93~~ ~~j. "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1, 1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, *etc.*~~

~~04/11~~ ~~k. "State Plan Rate Year", for purposes of the independent certified audit of the State's DSH program, shall mean the twelve month period beginning on July 1st and ending on June 30th of the rate year. For example, State Plan Rate Year 2011 begins on July 1, 2010 and ends June 30, 2011.~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

[MATERIAL REMOVED]

~~10/93~~ ~~d. "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal *Social Security Act* (42 *U.S.C.* Sec. 1396a *et seq.*) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Sections C.3.a and C.3.b of this Chapter. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.~~

07/95 D. *Public Law 103-66*

~~07/95~~ 1. *Public Law 103-66* Requirements

07/14 ~~07/95~~ a. Each cost reporting hospital as described in Chapter VIII, Section G, shall annually submit, on or before August 15, of the rate year, at least the following information separated by inpatient and outpatient (including hospital-based clinic services) to the Department:

~~07/95~~ i. The dollar amount of hospital bad debt, less any recoveries, ~~uncompensated care charges~~ rendered in the base year for uninsured patients.

~~07/95~~ ii. The dollar amount of hospital charity care charges rendered in the base year for uninsured patients.~~that are reimbursable by the Department for those program participants covered under the Family and Children Assistance Program, formerly known as the General Assistance Program (Article VI of the *Public Aid Code*).~~

~~07/95~~ iii. The dollar amount of Illinois Medicaid charges rendered in the base year

~~07/95~~ iv. The dollar amount of Illinois total charges for care rendered in the base year

07/95 b. Definitions

10/92 i. "Medicaid charges " means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the *Social Security Act*.

07/95 ii. "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.

07/14 ~~07/95~~ iii. "Base- year" means the hospitals fiscal year ending in the calendar year, 22 months before the beginning of the DSH determination year. ~~July 1 through June 30 of each year beginning with July 1, 1994 through June 30, 1995.~~

07/14 ~~07/95~~ iv. "Hopsital charity care charges" and "hospital bad debt" means: ~~"Uncompensated care charges" for a hospital means:~~

~~10/94~~ A) the hospital's charges for inpatient, outpatient and hospital-based clinic services provided to individuals without health insurance or other sources of third-party coverage. For purposes of the previous state ment in this subsection b.vi., State or unit of local government payments made to a hospital on behalf of indigent patients is not considered to be a form of insurance or a source of third-party coverage. Unreimbursed charges for persons covered under these programs may be included. ~~for which the hospital was not reimbursed by either the patient or a third party (including the Department);~~

B) Charity care charges and bad debt Charity care charges and bad debt cannot include unpaid co-pays or third party obligations of insured patients, contractual allowances, or the hospital's charges or reduced charges attributable to services provided under its obligation pursuant to the federal *Hill-Burton Act* (42 *USC* 291). ~~Less:~~

~~10/92~~ ~~1) the amount of the hospital's bad debt recoveries for inpatient, outpatient and hospital-based clinic services; and~~

~~10/92~~ ~~2) the hospital's charges attributable to inpatient, outpatient and hospital-based clinic services that if provided without charge or at reduced charges under its obligation under the federal *Hill-Burton Act* (42 *U.S.C.* 291 *et seq.*).~~

07/95 E. County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:

07/95 1. The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in 4. below ~~2 above~~) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.

07/95 2. The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the *Social Security Act* for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the *Public Aid Code.*

07/95 3. The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.

07/95 4. Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this Section shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in Section E. above. In these instances, the adjustments calculated under this Section shall be pro-rated, as applicable, based upon the date that such recognition ceased.

07/95 5. Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by Section E are as follows:

07/95 a. "Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.

07/95 b. "Medicaid trauma admission" means those claims billed as admissions, for recipients of medical assistance under Title XIX of the *Social Security Act,* excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of:

800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.

For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18.

07/14 <u>For discharges after June 30, 2014, those services provided to Medicaid-enrolled beneficiaries that were received and processed as hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June, preceding the TCA rate period and contained within the Department's paid claims data base, and has been grouped to one of the following DRGs:</u>

020 Craniotomy for trauma.

055 Head trauma, with coma lasting more than one hour or hemorrhage.

056 Brain contusion/laceration and complicated skull fracture, coma less than one or no coma

057 Concussion, closed skull fracture not otherwise specified, uncomplicated intracranial injury, coma less than one hour or no coma.

135 Major chest and respiratory trauma.

308 Hip and femur procedures for trauma, except joint replacement.

384 Contusion, open wound and other trauma to skin and subcutaneous tissue.

910 Craniotomy for multiple significant trauma.

911 Extensive abdominal/thoracic procedures for multiple significant trauma.

912 Musculoskeletal and other procedures for multiple significant trauma.

930 Multiple significant trauma, without operating room procedure.

07/14 ~~07/95~~ c. "TCA base period" means the twelve-month period ending on the last day of June preceding the TCA rate period.~~State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.~~

07/14 ~~07/95~~ d. "TCA rate period" means, ~~beginning October 1, 1992,~~ the 12-month period beginning on October 1 of the year and ending September 30 of the following year.

07/14 ~~07/95~~ e. ~~"Trauma Center Fund" means the fund created in the State treasury by Section 5.325 of the State Finance Act [30 ILCS 105] and described in Section 3.225 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50] and Section 5-5.03 of the Public Aid Code [305 ILCS 5]~~"Trauma Center Fund " means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by Section E.4.

07/95 F. Medicaid High Volume Adjustments (MHVA)

07/14 ~~10/03~~ 1. ~~For inpatient admissions occurring on or after October 1, 2003, the~~ The Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals that are eligible to receive the adjustment payments described in Section G. of this Chapter.

~~07/95~~ ~~1. Criteria. To qualify for MHVA adjustments under this Section, hospitals must meet the following criteria:~~

~~07/95~~ ~~a. Be eligible to receive the adjustment payments described in Section G. of this Chapter in the MHVA rate period;~~

~~07/95~~ ~~b. Not be a county-owned hospital, as described in Section A.1.a.i of Chapter XVI, or a hospital organized under the *University of Illinois Hospital Act*, as described in Section A.1.a.ii of Chapter XVI, in the MHVA rate period; and~~

~~07/95~~ ~~c. Not be a facility operated by the Department of Mental Health and Developmental Disabilities, as described in Section A.7 of Chapter XVI.~~

10/03 2. Calculation of Medicaid High Volume Adjustments

~~07/95~~ a. Hospitals meeting the criteria specified in Section F.1 above shall receive a MHVA payment adjustment of $60.

~~07/95~~ b. For children's hospitals, as defined in Section C.1.e.of this Chapter, the payment adjustment calculated under Section F.2.a above shall be multiplied by 2.0.

07/14 ~~07/95~~ c. The amount calculated pursuant to Sections F.2.a and F.2.b. above shall be adjusted ~~as authorized in Section 5-5.02 of the Illinois Public Aid Code.~~ by the aggregate annual increase in the national hospital market price proxies (DRI) hospital cost index (from the most recent publication of Health-Care Cost Review, published by Global Insight, located at 24 Hartweil Avenue, Lexington, MA) from the MHVA rate period – 1993, as defined in F.4.. through the MHVA rate period 2003, and annually thereafter, by a percentage equal to the lesser of~~;~~ the increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent twelve month period for which data are available.

~~i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent twelve month period for which data are available; or~~

~~07/95~~ ~~ii. The percentage increase in the statewide average hospital payment rate, as described in Section F.4.c. of this Chapter, over the previous year's statewide average hospital payment rate.~~

07/95 d. The adjustments calculated under Sections F.2.a.through F.2.c. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.

~~3. Medicaid High Volume Adjustment Limitations.~~

~~07/95~~ ~~Hospitals that qualify for MHVA adjustments under Sections F.2.a throughF.2.c above shall not be eligible for such MHVA adjustments if they are no longer recognized or designated by the Department as a DSH hospital, as required by Section F.1.a. In this instance, the annual adjustment described in Sections F.2.a through F.2.c. shall be pro-rated, as applicable, based upon the date that the hospital was deemed ineligible for DSH payment adjustments, under Section C. of this Chapter, by the Department.~~

3. Payment. The adjustments calculated under section F. shall be paid on a per diem basis and shall be applied to each covered day of care provided so long as the hospital meets the criteria in subsection 1.A. of the covered day.

~~i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent twelve month period for which data are available; or~~

~~07/95~~ ~~ii. The percentage increase in the statewide average hospital payment rate, as described in Section F.4.c. of this Chapter, over the previous year's statewide average hospital payment rate.~~

~~07/95~~ ~~4. Medicaid High Volume Adjustment Definitions. The definitions of terms used with reference to calculation of the MHVA adjustments required by Section F. are as follows:~~

~~07/95~~ ~~a. "MHVA base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, MHVA determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, MHVA determination year, etc.~~

~~07/95~~ ~~b. "MHVA rate period" means, beginning October 1, 1993, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~

~~07/95~~ ~~c. "Statewide Average Hospital Payment Rate" means the hospital's alternative reimbursement rate, as defined in Section B. of Chapter VIII.~~

07/14 ~~10/03~~ G. Medicaid Percentage Adjustments.

1. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, of each year, ~~2003, and each October 1 thereafter~~ unless otherwise noted.

   a. Qualified Medicaid Percentage Hospitals. ~~For inpatient services provided on or after October 1, 2003, the~~ The Department shall make adjustment payments to hospitals that are deemed as a Medicaid percentage hospital by the Department. A hospital may qualify for a Medicaid Percentage Adjustment in one of the following ways:

      i. The hospital's Medicaid inpatient utilization rate (MIUR), as defined in Section ~~C.8.c 148.120(i)(4)~~ C.8.d., is at least one-half standard deviation above the mean Medicaid utilization rate, as defined in Section C.8.c.~~C.8.e. 148.120(i)(3)C.8.d.~~

      ii. The hospital's low income utilization rate as defined Section C.8.g. ~~148.120(i)(6)~~ exceeds 25 per centum. ~~For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children~~

~~Assistance (formerly known as General Assistance) and/or any local or State government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for Family and Children Assistance inpatient hospital services, and/or any local or State government-funded care) must be added.~~

iii. Illinois hospitals that, on July 1, 1991, had an MIUR, as defined in Section C.8.d.~~C.8.c. Section 1489.120(i)(4) C.8.d~~, that was at least the mean Medicaid inpatient utilization rate, as defined in Section ~~148.120(i)(3) C.8.c.~~C.8.c., and that were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board ~~(77 Ill. Adm. Code 1100)~~, and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5 [1989]~~(1989)~~).

iv. Illinois hospitals that meet the following criteria:

A. Have an MIUR, as defined in Section C.8.d.~~C.8.c.~~148.120(i)(4)~~,~~ that is at least the mean Medicaid inpatient utilization rate, as defined in Section ~~C.8.c.~~C.8.c.~~148.120(i)(3).; and~~

B. Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection G.1.h.iii. ~~(g)(3)~~ of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection G.1.h.~~a.~~ii.~~(g)(2)~~ of this Section.

v. Any children's hospital, as defined in ~~Section 148.25(d)(3)~~ Chapter VII ~~Chapter II.C.3~~. of this Attachment.

vi. Out of state hospitals meeting the criteria in Chapter VI.C.5.~~ Section 148.120(e)C.5~~.

b. In making the determination described in subsections G.1.a.i. and G.1.a.iv. of this Section, the Department shall utilize the data described in Section ~~148.120(c)~~ C.3. and received in compliance with Section ~~148.120(f)~~ C.6 of this Chapter.

07/14

c. Hospitals that ~~may apply to become a~~ qualified as a Medicaid Percentage Adjustment hospital under subsection G.1.a.ii.of this Section for the Medicaid percentage determination year beginning October 1, 2013, may apply annually to become qualified under G.1.a.ii.by submitting audited certified financial statements as described in ~~Section 148.120(d)~~ C.4. and received in compliance with Section ~~148.120(f)~~ C.6. of this Chapter.

d. Medicaid Percentage Adjustments for hospitals defined in Chapter XVI, Sections A.1. and A.2., excluding hospitals defined in Section A.1.a.i. of Chapter XVI.

i. The payment adjustment shall be calculated based upon the hospital's MIUR, as defined in Section C.8.d. of this Chapter ~~148.120(i)(4)~~, and subject to subsection e. of this Section, ~~C.8.d. of this Chapter~~, as follows:

A. Hospitals with a MIUR below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;

B. Hospitals with an MIUR that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's MIUR exceeds the mean Medicaid inpatient utilization rate;

C. Hospitals with an MIUR that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's MIUR exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

D. Hospitals with an MIUR that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's MIUR exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

ii. Reserved. ~~For hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., the amount calculated pursuant to Section G.1.d. above shall be increased by $60 per day.~~

iii. The Medicaid percentage adjustment payment, calculated in accordance with this Section, to a hospital~~, other than hospitals organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI.~~, shall not exceed $155 per day for a children's hospital, as defined ~~described~~ in ~~Section 148.25(d)(3)~~ Chapter VII ~~Chapter II, Section C.3. of this Chapter~~, and shall not exceed $215 per day for all other hospitals.

07/14

iv. The amount calculated pursuant to Section G.1.d.i-iii. above shall be adjusted by the aggregate annual increase in the national hospital market basket price proxies (DRI) Hospital Cost Index from DSH determination year 1993, as defined in Section C.8.b of this Chapter ~~148.120(i)(2)~~, through DSH determination year 2003 and annually thereafter ~~2014~~ by a percentage equal to the lesser of :~~on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of:~~

A. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

B. The percentage increase in the Statewide average hospital payment rate, over the previous year's Statewide average hospital payment rate.~~The percentage increase in the Statewide average hospital payment rate, as described in subsection (g)(5) of this Section, over the previous year's Statewide average hospital payment rate.~~

v. The amount calculated pursuant to G.1.d.i. through G.1.d.iv. of this Chapter, ~~as adjusted pursuant to G.1.e. and G.1.f.,~~ shall be the inpatient payment adjustment in dollars for the applicable Medicaid percentage determination year. The adjustments calculated under G.1.d.i. through G.1.d.iv. of this Chapter shall be paid on a per diem basis and shall be applied to each covered day of care provided.

e. Inpatient Adjustor for Children's Hospitals. For a children's hospital, as defined in Chapter VII ~~Section Chapter II, Section C.3. of this Chapter 148.25(d)(3) 89 Ill. Adm. Code 149.50(e)(3)~~, the payment adjustment calculated under subsection d.i. of this Section shall be multiplied by 2.0.

07/14

f. Reserved. ~~Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital organized under the University of Illinois Hospital Act, as defined in Section A.1.a.ii. of Chapter XVI., the payment adjustment calculated under Section G.1.d.i., above shall be multiplied by 1.50.~~

g. Medicaid Percentage Adjustment Limitations.

i. In addition, to be deemed a Medicaid Percentage Adjustment hospital, a hospital must provide to the Department, in writing, the

names of at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the federal Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges to perform non-emergency obstetric procedures at the hospital. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age, or does not offer non-emergency obstetric services as of December 22, 1987. Hospitals that do not offer non-emergency obstetrics to the general public, with the exception of those hospitals described in Chapter VII ~~Section 148.25(d) Chapter II, Section C.1 through C.4.~~ must submit a statement to that effect.

ii. Hospitals that qualify for Medicaid Percentage Adjustments under this Section shall not be eligible for the total Medicaid Percentage Adjustment if, during the Medicaid Percentage Adjustment determination year, the hospital discontinues provision of non-emergency obstetrical care. The provisions of this subsection ~~G.1.g.ii.~~ shall not apply to those hospitals described in Chapter VII ~~Section 148.25(d)Chapter II, Section C.1. through C.4.,~~ or those hospitals that have not offered non-emergency obstetrical services as of December 22, 1987. In this instance, the adjustments calculated under subsection G.1.d. shall cease to be effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

iii. Appeals based upon a hospital's ineligibility for Medicaid Percentage payment adjustments, or their payment adjustment amounts, in accordance with Chapter IX ~~Section 148.310(b)Chapter XIV, Section C~~., which result in a change in a hospital's eligibility for Medicaid Percentage payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the Medicaid Percentage status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of its eligibility for Medicaid Percentage payment adjustments based upon the requirements of this Section.

iv. Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for Medicaid percentage payment adjustments under this Section shall not be eligible for Medicaid percentage payment adjustments if the hospital's MIUR, as defined in Section ~~148.120(i)(4)~~C.8.d., is less than one percent.

h. Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of Inpatient Payment Adjustments are as follows:

i. "Medicaid Percentage determination year" means the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~has the same meaning as the DSH determination year defined in Section 148.120(i)(2).~~

ii. "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in Section G.1.h.iv.~~C.8.g~~. below, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal ~~Federal~~ Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid inpatient days, as defined in Section G.1.h.vi.~~C.8.i.~~ below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid percentage ~~DSH~~ determination year and contained within the Department's paid claims data base.

iii. "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection G.1.h.iv. ~~(g)(4)~~ of this Section, provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 USC 1396a), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection G.1.h.vi. ~~(g)(6)~~ of this Section, provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base.

07/14

iv. "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage ~~Adjustment~~ determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, (specifically excluding Medicare/Medicaid crossover claims) with a Diagnosis Related Grouping (DRG) of: ~~370 through 375, and specifically excludes Medicare/Medicaid crossover claims.~~

A. 370 through 375 for discharges before July 1, 2014; or

B. 540, 541, 542, or 560 for discharges on or after July 1, 2014.

07/14

v. "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section B.1.of Chapter VIII ~~148.270(a).~~

vi. "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (g)(2) and (g)(3) of this Section, means hospital inpatient days, excluding days for normal newborns, that were subsequently adjudicated by the Department through the last day of June preceding the Medicaid Percentage determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

vii. "Medicaid obstetrical inpatient utilization rate base year" means, the State fiscal year ending 15 months before the for example, fiscal year 2002 for the October 1, 2003, Medicaid Percentage Adjustment determination year; fiscal year 2003 for the October 1, 2004, Medicaid Percentage Adjustment determination year.; etc.

viii. "Obstetric services" shall at a minimum include non-emergency inpatient deliveries in the hospital.

H. Inpatient Payment Adjustments Based Upon Reviews

Appeals based upon a hospital's ineligibility for the inpatient payment adjustments described in Sections E. and F. of this Chapter, or their payment adjustment amounts, in accordance with Chapter IX., which result in a change in a hospital's eligibility for inpatient payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the inpatient payment adjustments of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for inpatient payment adjustments based upon the requirements of Section E. and F. of this Chapter.

I. Reductions to Total Payments

07/95 1. Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance medical program, and shall be assessed in accordance with the Chapter.

07/95 2. Third Party Payments. Hospitals shall determine that services are not covered, in whole or in part, under any program or under any other private group indemnification or insurance program, health maintenance organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.

[MATERIAL REMOVED]

~~VII. Payments to Hospitals Under the DRG Prospective Payment System~~ Reserved.

~~09/91 A. Total Medicaid Payment~~

~~10/93 Under the DRG PPS, the total payment for inpatient hospital services furnished to a Medicaid client by a hospital will equal the sum of the payments listed in Sections B. through C. of this Chapter. In addition to the payments listed in Sections B. through C. of this Chapter, hospitals shall also receive disproportionate share adjustments, if applicable, uncompensated care adjustments, if applicable, and various specific inpatient payment adjustments in accordance with Chapter VI, if applicable.~~

~~10/93 B. Determination of Payment~~

~~10/93 A hospital will be paid the following amounts:~~

~~1. The appropriate DRG PPS rate for each discharge as determined in accordance with Chapter IV.~~

~~2. The appropriate outlier payment amounts determined under Chapter V.~~

~~10/93 3. Capital related costs as determined under Section C. of this Chapter.~~

~~07/95 C. Payments for Capital Costs.~~

~~07/95 For the rate periods described in Section B.2 of Chapter XVI., these costs shall be paid on a per case basis. Payments for these costs shall be calculated as follows:~~

~~10/93 1. Capital Related Costs~~

~~07/95 a. For the rate period described in Section B.2.a of Chapter XVI:~~

~~07/95 i. The capital related cost per diem shall be calculated by taking the hospital's total capital related costs as reported on the hospital's latest audited Medicare cost report on file with the Department for the base period as defined in Section B.1 of Chapter XVI., divided by the hospital's total inpatient days, trended forward to the mid-point of the rate period using the national total hospital market basket price proxies, (DRI).~~

~~10/93 ii. These two trended capital related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital related cost per diem.~~

VII. Definitions

"County-owned hospital" means all county-owned hospitals that are located in an Illinois county with a population of over three million.

"Distinct part unit"

For purpose of hospital inpatient reimbursement, the term "distinct part unit" means a unit within a hospital, as defined in subsection (b)(1) of this Section, that meets the following qualifications:

A. Distinct Part Psychiatric Units. A distinct part psychiatric unit is a functional unit that is enrolled with the Department to provide inpatient psychiatric services (category of service 021).

B. Distinct Part Rehabilitation Units. A distinct part rehabilitation unit is a functional unit that is enrolled with the Department to provide inpatient rehabilitation services (category of service 022).

"Hospital" means:

For the purpose of hospital inpatient reimbursement, any institution, place, building, or agency, public or private, whether organized for profit or not-for-profit, which:

A. Is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act.

B. Is organized under the University of Illinois Hospital Act.

C. Is maintained by the State, or any department or agency thereof, where such department or agency has authority under the law to establish and enforce standards for the hospitalization or care facilities under its management and control.

D. Which meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.

"Large public hospital" means a hospital:

A. Owned by and located in an Illinois county with a population exceeding three million; or

B. Organized under the University of Illinois Hospital Act; or

C. Maintained by the Illinois Department of Human Services.

"Major teaching hospital" means a hospital having four or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation. Except, in the case of a hospital devoted exclusively to physical rehabilitation, only one certified program is required to be so classified.

[MATERIAL REMOVED]

~~10/93~~ ~~iii. The adjusted capital-related cost per diem amount as calculated in Section C.1.a.ii above shall be rank ordered for all hospitals and capped at the 80th percentile.~~

~~10/93~~ ~~iv. Each hospital shall receive a per case add-on for capital-related costs which shall be equal to the amount calculated in Section C.1.a.ii or C.1.a.iii above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.~~

~~07/95~~ ~~b. For the rate periods described in Section B.2.b. of Chapter XVI:~~

~~10/93~~ ~~i. Capital related costs per diem shall be calculated in accordance with Sections C.1.a.i through C.1.a.iii.above.~~

~~07/95~~ ~~ii. Each hospital shall receive a per diem add-on for capital related costs which shall be equal to the amount calculated in Section C.1.a.i or Section C.1.a.iii above, whichever is less, multiplied by the hospital's average length of stay for services reimbursed under the DRG PPS.~~

~~07/95~~ ~~2. A hospital wishing to appeal the calculation of its rates must notify the Department within 30 days after receipt of the rate change notification, in accordance with the provisions of Chapter IX.~~

~~09/91~~ ~~D. Method of Payment~~

~~1. General Rule~~

~~Unless the provisions of Section D.2. of this Chapter apply, hospitals are paid for each discharge based on the submission of a discharge bill. Payments for inpatient hospital services furnished by an excluded distinct part psychiatric or a rehabilitation unit of a hospital are made under Alternate Reimbursement Systems set forth in Chapter VIII.~~

~~2. Special Interim Payment for Unusually Long Lengths of Stay~~

VII. Definitions (continued)

Specialty Hospitals.

A. Psychiatric Hospitals. To qualify as a psychiatric hospital, a facility must be:

1. Licensed by the state within which it is located as a psychiatric hospital and be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons.

2. Enrolled with the Department as a psychiatric hospital to provide inpatient psychiatric services (category of service 021).

B. Rehabilitation Hospitals. To qualify as a rehabilitation hospital, a facility must be:

1. Licensed by the state within which it is located as a physical rehabilitation hospital.

2. Enrolled with the Department as a rehabilitation hospital to provide inpatient physical rehabilitation services (category of service 022).

C. Children's Hospitals. To qualify as a children's hospital, a facility must be devoted exclusively to caring for children and either be:

1. A hospital licensed by the state within which it is located as a pediatric, psychiatric, or children's hospital.

2. A unit within a general hospital that was enrolled with the Department as a children's hospital on July 1, 2013. Units so enrolled shall be reimbursed for all inpatient and outpatient services provided to Medical Assistance enrollees who are under 18 years of age, with the exception of obstetric services, normal newborn nursery services, psychiatric services, and physical rehabilitation services, without regard to the physical location within the hospital where the care is rendered.

D. Children's specialty hospital. To qualify as a children's specialty hospital, a facility must be an Illinois hospital as defined in subsection C.1.~~(d)(3)(A)~~ of this Section and have fewer than 50 total inpatient beds

"State-owned hospital" means a hospital organized under the University of Illinois Hospital Act.

[MATERIAL REMOVED]

~~a. First Interim Payment~~

~~A hospital may request an interim payment after a Medicaid client has been in the hospital at least 60 days. Payment for the interim bill is determined as if the bill were a final discharge bill and includes any outlier payment determined as of the last day for which services have been billed.~~

~~b. Additional Interim Payments~~

~~A hospital may request additional interim payments at intervals of at least 60 days after the date of the first interim bill submitted under Section D.2.a of this Chapter. Payment for these additional interim bills, as well as the final bill, is determined as if the bill were the final bill with appropriate adjustments made to the payment amount to reflect any previous interim payment made under the provisions of Section D.2.of this Chapter.~~

~~3. Outlier Payments~~

~~Except as provided in Section D.2 of this Chapter, payment for outlier cases (described in Chapter V.) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.~~

~~09/91~~ ~~E. Reductions to Total Payments~~

~~1. Co-payments~~

~~07/12~~ ~~Co-payments will be assessed on inpatient hospital services in accordance with Attachment 4.18-A.~~

[MATERIAL REMOVED]

~~2. Third-Party Payments~~

~~Hospitals shall determine that services rendered are not covered, in whole or in part, under any other state or federal medical care program or under any other private group indemnification or insurance program, health maintenance organization, preferred provider organization, workers compensation or the tort liability of any third party. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

~~09/91~~ ~~F. Effect of Change of Ownership on Payments under the DRG Prospective Payment System. When a hospital's ownership changes, the following rules apply~~

~~1. The owner on the date of discharge is entitled to submit a bill for all inpatient hospital services furnished to a Medicaid client regardless of when the client's coverage began or ended during a stay, or of how long the stay lasted.~~

~~2. Each bill submitted must include all information necessary for the Department to compute the payment amount, whether or not some of that information is attributable to a period during which a different party legally owned the hospital.~~

~~07/97~~ ~~G. All payments calculated under Sections B and C above, in effect on January 18, 1994, shall remain in effect hereafter.~~

[MATERIAL REMOVED]

~~VIII. Alternate Reimbursement Systems~~

~~09/91~~ ~~A. Determination of Alternate Payment Rates to Certain Exempt Hospitals~~

~~1. The exempt hospitals, defined in Sections C.1, C.2. C.4, and C.7 of Chapter II, shall be reimbursed for inpatient hospital care provided to recipients by summing the following reimbursement calculations:~~

~~a. Allowable operating cost per diem~~

~~07/95~~ ~~b. capital costs reimbursed on a per diem basis;~~

~~07/95~~ ~~c. applicable disproportionate share adjustments as described in Section C. of Chapter VI and outlier adjustments as described in Section F. of this Chapter; and~~

VIII. Alternate Reimbursement Systems Defined in Chapter II of this Attachment

A. Determination of Alternate Payment Rates to Certain Exempt Hospitals

1. Reimbursement Methodologies For Inpatient Psychiatric Services Base

a. Inpatient psychiatric services not excluded from the DRG PPS pursuant to Chapter II of this Attachment shall be reimbursed through the DRG PPS. Qualifying Criteria.

b. Inpatient psychiatric services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsections (c), ~~or~~ (d), or (f) as applicable. The total payment for an inpatient stay will equal the sum of:

i. the payment determined in this Section;~~,~~ and

ii any applicable adjustments to payment specified in Chapters VI, VIII, XV and XL.~~89 Ill. Adm. Code 148.290.~~

c. Psychiatric hospital. Payment for inpatient psychiatric services provided by a psychiatric hospital, as defined in Chapter VII. ~~Appendix to Attachment 3.1-A~~

i. For psychiatric hospitals not enrolled with the Department on June 30, 2014, shall be the product of: ~~For which the Department had not inpatient base period paid claims data, shall be the product of~~:

A) The lowest hospital psychiatric rate determined pursuant to subsection A.1.e.~~1.A.f.~~ of this Chapter; and

B) The length of stay. The length of stay means the number of days the patient was an inpatient in the hospital; with the day the patient became a discharge or transfer not counting the length of stay.~~, as defined in 89 Ill. Adm. Code 149.100(i).~~

ii.~~,~~ For psychiatric hospitals enrolled with the Department on June 30, 2014, shall be the product of:~~ For which the Department had inpatient base period claims data, shall be the product of the following:~~

A) The hospital's psychiatric rate, as determined in subsection A.1.e. ~~A.1.f.~~of this Chapter.

B) The length of stay, as defined in subsection A.1.c.i.B. above.

[MATERIAL REMOVED]

~~07/95~~ ~~d. Applicable trauma center adjustments and Medicaid high volume adjustments as described in Sections E. and F. of Chapter VI and Critical Hospital Adjustment Payments as described in Chapter XV.~~

~~10/10~~ ~~e. Effective October 1, 2012, for hospitals defined in Section C.4. of Chapter II, the LTAC Hospital Supplemental Per Diem Rate as described in subsection A.3. of this Chapter.~~

~~2. Calculation and definitions of inpatient per diem rates.~~

~~10/92~~ ~~a. Calculation for the first rate period~~

~~i. Allowable operating cost per diem~~

~~07/95~~ ~~A) The allowable operating cost per diem for a hospital, described in Section A.1.of this Chapter, and for hospitals or hospital units, described in Sections B1 and B2 of this Chapter, shall be calculated by taking the hospital's Medicaid inpatient operating costs for the base period, as defined in Section B.1 of Chapter XVI, divided by the hospital's Medicaid inpatient days.~~

~~10/92~~ ~~B) Operating cost base per diem rates for hospital inpatient care provided to Medicaid recipients beginning September 1, 1991, shall be calculated by:~~

d. Distinct part psychiatric unit. Payment for psychiatric services provided by a distinct part psychiatric unit, as defined in Chapter VII ~~Appendix to Attachment 3.1-A~~:

i. For which the Department had no inpatient base period paid claims data, shall be the product of the following:

A). 80 percent of the arithmetic mean transition rate for psychiatric distinct part units, and

B). The length of stay, as defined in subsection A.1.c.i.B. above. ~~in 89 Ill. Adm. Code 149.100(i).~~

ii. For which the Department had inpatient base period paid claims data, shall be the product of the following:

A) The lesser of:

1) The greater of:

a) The distinct part psychiatric unit rate, as determined in subsection A.1.f of this Chapter, and

b) 80 percent of the arithmetic mean psychiatric rate for psychiatric distinct part units.

2) The arithmetic mean r rate for psychiatric distinct part units plus the value of two standard deviations of the psychiatric rate for psychiatric distinct part units.

e. The psychiatric rate is calculated as the sum of:

i. The per diem rate for psychiatric services in effect on June 30, 2014 ~~July 1, 2011~~.

ii. The quotient, rounded to the nearest hundredth, of the psychiatric provider's allocated static payments divided by the psychiatric provider's inpatient covered days in the inpatient base period paid claims data.

f. Psychiatric hospital adjustors for dates of service beginning on or after July 1, 2014 through June 30, 2018. For Illinois freestanding psychiatric hospitals, defined in Chapter VII~~at 148.25(d)(1)~~, who were not children's hospitals as defined in Chapter VII~~at 148.25(d)(3)~~ in FY 2013 and whose Medicaid covered days were 90% or more for individuals under 20 years of age in FY 2013, the Department shall pay a per day add-on of $48.25.

[MATERIAL REMOVED]

~~1) Calculating each individual hospital's cost per diem less capital and direct medical education costs for each of the two most recent years for which an audited Medicaid cost report exists, as described in Section A.2.a.i.A) above.~~

~~10/92~~ ~~2) Each of the two cost per diems shall be trended forward to the midpoint of the rate period using the national total hospital market basket price proxies, (DRI).~~

~~07/95~~ ~~3) These two trended operating cost per diems are then added together and divided by two.~~

~~07/95~~ ~~4) The average operating cost per diem calculated in A2ai B) 3) of this Chapter is then divided by the indirect medical education (IME) factor, determined by the Health Care Financing Administration (HCFA), in effect 90 days prior to the admission in order to calculate the hospital's final operating cost per diem for the base period. For other hospitals for which an indirect medical education factor is not available, the Department shall calculate an indirect medical education factor using the hospital's most recently available cost report and the Medicare formula in effect 90 days prior to the date of admission.~~

~~ii. Capital related costs~~

~~07/95~~ ~~A) The capital related cost per diem for a hospital, described in Section A.1 of this Chapter, and for hospitals or hospital units, described in Sections B.1 and B.2 of this Chapter, shall be calculated by taking the hospital's total capital-related costs for the base period, as defined in Section B.1 of Chapter XVI, divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies, (DRI).~~

~~B. These two- trended capital-related cost per diems are then added together and divided by two to calculate the hospital's adjusted capital-related cost per diem.~~

gf. Definitions

"Allocated static payments" means the State plan approved adjustment payments in Chapter XV effective during State fiscal year 2011, excluding those payments that continue after July 1, 2014~~ made to the hospital pursuant to 89 Ill. Adm. Code 148.85 through 148.117 and 148.295 through 148.297 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in: http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx , as determined by the Department~~, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for psychiatric payment for services provided in State fiscal years 2015 and 2016.

[MATERIAL REMOVED]

~~C) The adjusted capital-related cost per diem as calculated in A.2.a.ii.B) above shall be rank ordered for all hospitals and capped at the 80thpercentile.~~

~~D) Each hospital shall receive a per diem add-on for capital-related costs which shall be equal to the amount calculated in Sections A.2.a.ii.B) or A.2.a.ii.C) above, whichever is less.~~

~~iii. Direct medical education costs~~

~~07/95~~

~~A) The direct medical education costs for a hospital described in Section A.1 above, and for hospitals or hospital units described in Sections B.1 and B.2 below, shall be calculated by taking total inpatient direct medical education costs for the base period, as defined in Section B.1 of Chapter XVI, divided by the hospital's total inpatient days, trended forward to the midpoint of the rate period using the national total hospital market basket price proxies, (DRI).~~

~~B) These two trended direct medical education cost per diems are then added together and divided by two to calculate the hospital's adjusted direct medical education cost per diem.~~

2. Reimbursement Methodologies for Inpatient Rehabilitation Services

a. Inpatient rehabilitation services not excluded from the DRG PPS ~~pursuant to 89 Ill. Adm. Code 149.50(b)~~ shall be reimbursed through the DRG PPS.

b. Inpatient rehabilitation services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to subsections (c) or (d), as applicable. The total payment for an inpatient stay will equal the sum of:

i. the payment determined in this Section, and

ii. any applicable adjustments to payment specified in Chapters VI, VIII, XV and XL.~~89 Ill. Adm. Code 148.290~~.

c. Rehabilitation hospital. Payment for inpatient rehabilitation services provided by a rehabilitation hospital, as defined in Chapter VII ~~Appendix to Attachment 3.1-A~~:

i. For which the Department had no inpatient base period claims data, shall be the product of the following:

A) 80 percent of weighted average rehabilitation hospital rate and

B) The length of stay, as defined in subsection A.1.c.i.B. above. ~~in 89 Ill. Adm. Code 149.100(i).~~

ii. For which the Department had inpatient base period claims data, shall be the product of the following:

A). The greater of:

1) the hospital's rehabilitation rate, as determined in subsection A.2.e ~~f~~ of this Chapter, and

2) 80 percent of the weighted average rehabilitation hospital rate.

B) The length of stay, as defined in subsection A.1.c.i.B. above. ~~in 89 Ill. Adm. Code 149.100(i).~~

[MATERIAL REMOVED]

~~C) The adjusted direct medical education cost per diem as calculated in Section A.2.a.iii.B) above shall be rank ordered for all hospitals reporting such costs and capped at the 80th percentile.~~

~~D) Each hospital shall receive a per diem add-on for direct medical education costs which shall be equal to the amount calculated in Sections A.2.a.iii.B) or A.2.a.iii.C) above, whichever is less.~~

d. Distinct part rehabilitation unit. Payment for inpatient rehabilitation services provided by a distinct part rehabilitation unit, as defined in Chapter VII ~~Appendix to Attachment 3.1-A:~~

i. For which the Department had no inpatient base period paid claims data, shall be the product of the following:

A) The arithmetic mean rate for rehabilitation distinct part units.

B) The length of stay, as defined in subsection A.1.c.i.B. above. ~~in 89 Ill. Adm. Code 149.100(i).~~

ii. For which the Department had inpatient base period paid claims data, shall be product of the following:

A). The lesser of:

1) The greater of:

a) The distinct part rehabilitation unit rate, as determined in subsection A.2.e.~~f~~ of this Chapter, and

b) 80% of the ~~The~~ arithmetic mean rate for rehabilitation distinct part units

2) The arithmetic mean rehabilitation rate for rehabilitation distinct part units plus the value of one standard deviation of the rehabilitation rate for rehabilitation distinct part units.

e. The rehabilitation rate is calculated as the sum of:

i. The rehabilitation rate as in effect on July 1, 2011.

ii. The quotient, rounded to the nearest hundredth, of the rehabilitation provider's allocated static payments divided by the rehabilitation provider's inpatient covered days in the inpatient base period paid claims data.

[MATERIAL REMOVED]

~~07/95~~ ~~b. Calculation for subsequent rate periods~~

~~07/95~~ ~~i. For the rate period described in Section B.2.a of Chapter XVI, the final rate per diem shall be determined by taking the operating, capital, and direct medical education trended rate cost per diems calculated under Section A.2.a of this Chapter and updating those costs by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section B.2.a.of Chapter XVI.~~

~~07/95~~ ~~ii. For rate periods beginning on or after April 1, 1994, as described in Section B.2.b. of Chapter XVI, the final rate per diem for a hospital described in Section B. of Chapter VI shall be determined by:~~

~~10/93~~ ~~A) Adding the operating and capital trended rate cost per diems calculated under Sections A.2.a.i.and A.2.a.ii.of this Chapter that were in effect on June 30, 1993;~~

f. Definitions

"Allocated static payments" means the State plan approved adjustment payments in Chapter XV effective during State fiscal year 2011, excluding those payments that continue after July 1, 2014 ~~made to the hospital pursuant to 89 Ill. Adm. Code 148.85 through 148.117 and 148.295 through 148.297 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in: http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department~~, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Inpatient base period paid claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, for psychiatric payment for services provided in State fiscal years 2015 and 2016.

~~B) Updating the trended rate cost per diems described in Section A.2.bi. A) above:~~

~~07/95~~ ~~1) In the case of a hospital described in Section C.7 of Chapter II, by the national hospital market basket price proxies (DRI) to the midpoint of the rate period described in Section B.2.b. of Chapter XVI; and~~

~~07/95~~ ~~2) In the case of a hospital described in Section C.1, C.2, or C.4, of Chapter II, or for a hospital unit described in Sections D.1 and D.2 of Chapter II, to the midpoint of the current rate period described in Section B.2.b. of Chapter XVI, by utilizing the TEFRA price inflation factor.~~

~~07/95~~ ~~c. Rebasing~~

~~For the rate period beginning after October 1, 1994, and every third rate period thereafter, the final rate per diem shall be calculated using the methodology set forth in Section A.2.a of this Chapter for the calculation of operating and capital trended rate cost per diems using base period cost reports, as described in Section B.1 of Chapter XVI.~~

10/10 3. Long Term Acute Care (LTAC) Hospital Supplemental Per Diem

a. Qualifying Criteria – effective October 1, 2010, to receive the LTAC Hospital Supplemental Per Diem, a hospital must do the following:

i. Operate as a LTAC hospital as defined in subsection A.3.c.iii.

ii. Employ one-half of an FTE (designated for case management) for every 15 patients admitted to the hospital.

iii. Maintain on-site physician coverage 24 hours per day and seven days per week.

iv. Maintain on-site respiratory therapy coverage 24 hours per day and seven days per week.

v. Retain patient admission evaluations to document that the patients meet the LTAC hospital criteria, as defined in subsection A.3.c.iv.

vi. Execute a program participation agreement with the Department that includes requirements for the hospital regarding the submittal of discharge status information, patient satisfaction survey results, quality and outcome measurement data, and access to patient data, as well as the acceptance of approved patients.

b. LTAC Hospital Supplemental Per Diem rate.

i. The LTAC Supplemental Per Diem rate will be paid to qualifying LTAC hospitals on a per diem basis for patients:

A) Who upon admission to the LTAC hospital meet LTAC hospital criteria as defined in subsection A.3.c.iv., and

B). Whose care is primarily paid under Title XIX of the Social Security Act, or if dually eligible under Medicare, after the patient has exhausted their benefits under Medicare.

ii. The LTAC Hospital Supplemental Per Diem rate will not be paid if any of the following conditions are met:

A) The LTAC hospital no longer meets the requirements of subsection A.3.a. of this Chapter, or terminates the agreement required under subsection A.3.a.6. of this Chapter.

B) The patient does not meet the LTAC hospital criteria, as defined in subsection A.3.c.iv. upon admission.

C) The patient's care is primarily paid for by Medicare and the patient has not exhausted their Medicare benefits.

iii. The LTAC Hospital Supplemental Per Diem rate shall be calculated using the LTAC hospital's Inflated Cost Per Diem, as defined in subsection A.3.c.ii. and subtracting the following:

A) The LTAC hospital's Medicaid per diem inpatient rate as calculated in subsection A.2. of this Chapter.

B) The LTAC hospital's disproportionate share (DSH) rate as calculated in subsection C.7. of Chapter VI.

C) The LTAC hospital's Medicaid Percentage Adjustment (MPA) as calculated in subsection C.7.b. of Chapter VI.

D) The LTAC hospital's Medicaid High Volume Adjustment (MHVA) rate as calculated in Section F. of Chapter VI.

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iv. The LTAC Supplemental Per Diem rates effective July 1, 2012 shall be the amount in effect as of October 1, 2010 and adjusted pursuant to ~~the~~ Chapter XXXIX. No new hospital may qualify for the program after July 1, 2012.

v. In the case of an Illinois hospital that begins operations as an LTAC hospital after January 1, 2009, that is designated by Medicare as a long term acute care hospital, and that does not have a filed cost report covering a twelve month period of operation as an LTAC provider, a default Supplemental Per Diem Rate shall be established as follows:

A) For a new LTAC provider that is part of a larger corporately held system of LTAC providers in the state of Illinois, the new providers' supplemental rate shall be the average of all supplemental per diem rates, as calculated in A.3.b.iii. of the other LTAC providers in the system.

B) For a new LTAC provider that is not part of a larger corporately held system of LTAC providers, the new providers' supplemental rate shall be the statewide average of all supplemental per diem rates as calculated in A.3.b.iii.

C) Default supplemental per diem rates calculated under A.3.b.v.(A). and v.(B) shall be in effect until such time as the provider has filed a cost report based on 12 months of operations as an LTAC hospital. At the next annual rate determination period, the hospital's 12 month cost report shall be used to determine the LTAC Hospital Supplemental Per Diem rate for the subsequent year.

c. Definitions.

i. Department – means the Illinois Department of Healthcare and Family Services.

ii. Inflated Cost Per Diem – means the quotient resulting from dividing the hospital's inpatient Medicaid costs by the hospital's Medicaid inpatient days and inflating it to the Rate Year by using the increase in the national hospital market basket price proxies (DRI) hospital cost index. Data is obtained from the LTAC hospital's most recent cost report submitted to the Department.

iii. LTAC Hospital – means an Illinois hospital defined in ~~subsection C.2. of~~ Chapter VII ~~II~~ with an average length of Medicaid inpatient stay of greater than 25 days as reported on the hospital's 2008 Medicaid cost report on file as of February 15, 2010, or a hospital that begins operations as an LTAC hospital after January 1, 2009 that is designated by Medicare as a long term acute care hospital.

iv. LTAC Hospital Criteria – means nationally recognized, evidence based evaluation criteria that have been publicly tested and includes criteria specific to an LTAC hospital for admission, continuing stay, and discharge.

v. Rate Year – means October 1 through September 30, with the first rate year being October 1, 2010 through September 30, 2011.

~~5. Nothing in these rules is intended prevent a hospital from individually negotiating with the Department to set up an alternate methodology for reimbursement that result in an expenditure which does not exceed the expenditure which would otherwise be made under this Sub-chapter A.~~

5. Reimbursement Methodology for Long Term Acute Care Services

a. Inpatient long term acute care psychiatric services excluded from the DRG PPS ~~pursuant to 89 Ill. Adm. Code 149.50(b)~~ shall be reimbursed under the inpatient psychiatric services methodologies specified in subsection A.1. of this Chapter ~~Section 148.110~~.

b. Inpatient long term acute care services excluded from the DRG PPS shall be reimbursed a hospital-specific rate paid per day of covered inpatient care, determined pursuant to this Section. The total payment for an inpatient stay will equal the sum of:

i. the payment determined in this Section;~~,~~ and

ii. any applicable adjustments to payment specified in Chapters VI, VIII, XV and XL.~~89 Ill. Adm. Code 148.290~~.

c. Payment for long term acute care services provided by a long term acute care hospital, as defined in Section 3.e. of this subsection. ~~Section 148.25(d)(4)~~:

i. For which the Department had no inpatient base period paid claims data, shall be the product of the following:

A) $604.00;~~,~~ and

B) The length of stay, as defined in subsection A.1.c.i.B. of this Chapter. ~~in 89 Ill. Adm. Code 149.100(i).~~

ii. For which the Department had inpatient base period paid claims data, shall be the product of the following:

A) The hospital-specific rate, as determined in subsection (d)

B) The length of stay, as defined in subsection A.1.c.i.B. of this Chapter. ~~in 89 Ill. Adm. Code 149.100(i).~~

d. The hospital-specific rate is calculated as the sum of:

i. The per diem rate for long term acute care services in effect on July 1, 2011.

ii. The quotient, rounded to the nearest hundredth, of the hospital's allocated static payments divided by the hospital's covered days in the inpatient base period paid claims data.

e. Definitions

"Allocated static payments" means the State plan approved adjustment payments in Chapter XV effective during State fiscal year 2011, excluding those payments that continue after July 1, 2014~~ made to the hospital pursuant to 89 Ill. Adm. Code 148.85 through 148.117 and 148.295 through 148.297 during State fiscal year 2011, excluding those payments that continue after July 1, 2014, pursuant to the methodologies as outlined in: http://www2.illinois.gov/hfs/PublicInvolvement/hospitalratereform/Pages/Rules.aspx, as determined by the Department~~, allocated to general acute services based on the ratio of general acute claim charges to total inpatient claim charges determined using inpatient base period claims data.

"Long term acute care hospital" is a facility licensed by the state within which it is located as an acute care hospital and certified by Medicare as a long term care hospital.

"Inpatient base period paid claims data" means State fiscal year 2011 inpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims.

f. Long term acute care supplemental per diem rates.

i. The long term acute care supplemental per diem rates, as authorized under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155], shall be the amount in effect as of October 1, 2010.

ii. No new hospital may qualify under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act after June 14, 2012.

07/14 B. Determination of Alternate Cost Per Diem Rates For All Hospitals; Payment Rates Prior to July 1, 2014.

For Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals

10/93 1. Calculation of Alternate Cost Per Diem Rates for All Hospitals

07/95 For all hospitals, regardless of the hospital's reimbursement methodology, the Department shall first calculate the hospital's alternate cost per diem rate, as calculated under Section A.2.of this Chapter, derived from the provider's base period cost reports, as described in Section B.1 of Chapter XVI.

10/93 2. Calculation of Payment Rates for Certain Exempt Hospital Units

07/95 a. For admissions occurring within the rate period described in Section B.2.a.of Chapter XVI:

10/93 i. In the case of a distinct part unit, as described in Section D. of Chapter II, the Department shall divide the hospital's Medicaid charges per diem (identified on adjudicated claims submitted by the provider during the most recently completed fiscal year for which complete data are available) related to the distinct part unit by the hospital's total charge per diem for all claims for the same time period.

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i. Provided before August 1, 1998, shall be at the average rate calculated under subsection B.1; or

ii. Provided on or after August 1, 1998, for a children's hospital that was licensed as such by a municipality after June 30, 1995, shall be equal to the average rate calculated in Chapter VIII.C.2.for children's hospitals in existence before June 30, 1995, with an average length of stay that was less than 14 days as determined from the hospital's fiscal year 1994 cost report.

07/14 ~~09/91~~ C. Reimbursement for Children's Hospitals Prior to July 1, 2014

10/93 1. Initial Rate Period

10/93 a. For purposes of reimbursement, all children's hospitals, as defined in Section C.3 of Chapter II, are grouped into one peer group.

10/93 b. Each hospital's costs for the base period shall be derived from audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending during calendar year 1989.

10/92 c. These base year costs shall be updated, trended forward, from the midpoint of each hospital's base period to the midpoint of the rate period for which rates are being set according to the methodology of the national total hospital market basket price proxies, (DRI).

10/92 d. The children's hospitals' base period trended rates shall be used as the basis for calculating the group's median trended rate. Each individual hospital's trended rate is then compared to the group's median trended rate. Hospitals whose individual trended rates are higher than the median rates shall receive as a final inpatient payment rate their trended rate minus half the difference between their trended rate and the group's median trended rate. Hospitals whose trended rates are lower than the group's median trended rate shall receive as its final inpatient payment rate their individual trended rate plus half the difference between their trended rate and the group's median trended rate.

10/92 2. Subsequent Rate Periods

07/95 For the rate period beginning on October 1, 1992, as described in Section B.2.a of Chapter XVI, and for subsequent rate periods, as described in Section B.2.b. of Chapter XVI, the initial rate, as calculated under Section C.1.above, shall be updated from the midpoint of the base cost reporting period to the midpoint of the rate period using the national hospital market basket price proxies (DRI).

07/14 ~~09/91~~ D. Hospitals Reimbursed Under Special Arrangements Prior to July 1, 2014

10/93 Hospitals that, on August 31, 1991, had a contract with the Department under the ICARE Program, pursuant to Section 3-4 of the Illinois Health Finance Reform Act, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care for services provided on or after September 1, 1991, subject to the limitations described in Sections H. through J. of Chapter VIII.

07/95 E. Applicable adjustments for disproportionate share and various specific inpatient payment adjustments as specified in Chapter VI.

07/95 The criteria and methodology for making applicable disproportionate share and various specific inpatient payment adjustments to hospitals, which are exempt from the DRG PPS shall be in accordance with Chapter VI and Chapter XV.

07/95 F. Outlier Adjustments for Exceptionally Costly Stays

07/95 1. Outlier adjustments are provided for exceptionally costly stays provided by hospitals or distinct part units reimbursed on a per diem basis or hospitals reimbursed in accordance with Chapter II.

10/93 i. For hospitals that do not meet the definition of a DSH hospital under Sections C.1.a.through C.1.e of Chapter VI in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of one year; and

10/93 ii. For hospitals defined by the Department as DSH hospitals under Sections C.1.a.throughC.1.e.of Chapter VI .in the DSH determination year, the mean total covered charges for all claims for inpatient services provided to individuals under the age of six years.

d. "Rate for services provided" means the inpatient rate in effect for the type of services provided.

10/93 e. "Total covered charges" means the amount entered on the UB-92 or UB04 Uniform Billing Form for revenue code 001 in column 53 (Total Charges).

07/05 4. Notwithstanding the provisions of subsection F of this Section,-payment for outlier adjustments provided for exceptionally costly stays pursuant to Chapter VIII shall be determined as follows:

a. For admissions on or after December 3, 2001 through June 30, 2005, a factor of 0.22 in place of the factor 0.25 as described at Chapter VIII (F)(2)(c)(iv).

01/08 b. For admissions on or after July 1, 2005, through December 31, 2007, a factor of 0.20 as described at Chapter VIII (F)(2)(c)(iv).

01/08 c. For admissions on or after January 1, 2008, a factor of 0.17 in place of the factor 0.18 as described at Chapter VIII (F)(2)(c)(iv).

09/91 G. Filing Cost Reports

07/14 1. Excepting those operated by an agency of the United States government, all~~All~~ hospitals in Illinois~~,~~ and ~~those~~ hospitals in contiguous states, providing 100 or more inpatient days of care to Illinois program participants~~, and all hospitals located in states contiguous to Illinois that elect to be reimbursed under the DRG PPS,~~ shall be required to file Medicaid cost reports within 150 days of the close of the provider's fiscal year and submit a copy of the filed Medicare report. Any hospital accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) not eligible for or subject to Medicare certification shall be required to file financial statements, a statement of revenues and expenses by program and census logs by program and financial class. The Bureau of Health Finance may request an audit of the financial statements by an independent Certified Public Accountant (CPA) firm if the financial statements are to be used as the base year for rate analysis.

07/95 2. No extension of the due date will be granted by the Department unless the Centers for Medicare and Medicaid Services (CMS) grants an extension of the due date for the related Medicare cost report. Should CMS extend the Medicare cost report due date, the Department will extend the Medicaid and Medicare cost reports due date by an equivalent period of time.

10/93 3. Assessment or license fees mandated by law may be reported as allowable costs on the Medicaid cost report.

10/93 4. For a hospital that is electing to participate in the Illinois Medicaid Program and has not filed a Medicaid cost report before, the hospital must submit the two most recently audited Medicare cost report at the time of enrollment.

5. Cost Report Reviews

The Bureau of Health Finance shall audit the information shown on the cost reports. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions that may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis that support the request for review. No additional data shall be accepted after the 45 day period.

6. County owned hospitals and large public hospitals as ~~Hospitals~~ described in Chapter VII ~~Chapter II.C.8. Sections 148.25(a)(1) and 148.25(a)(2)~~ shall be required to submit outpatient cost reports to the Department within 150 days after the close of the facility's fiscal year.

~~[MATERIAL REMOVED]~~

07/14 ~~09/91~~ H. Reserved. ~~Transition to the Diagnosis Related Grouping Prospective Payment System (DRG PPS)~~

~~10/93~~ ~~1. Effective with admissions occurring on or after September 1, 1991, and before October 1, 1992, hospitals shall be reimbursed in accordance with the State plan governing the time period when the services were provided.~~

~~10/93~~ ~~2. Effective with admissions occurring on or after October 1, 1992, hospitals that, on August 31, 1991, had a contract in effect with the Department under the Illinois Health Finance Reform Act (Ill. Rev. Stat. Ch. 23, Par. 6505-1 et seq.) and that elected, effective September 1, 1991, to be reimbursed at rates stated in such contracts, may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care, in accordance with Section I. of this Chapter.~~

~~07/95~~ ~~3. In the case of a hospital that was determined by the Department to be a rural hospital at the beginning of the rate period described in Section B2a of Chapter XVI, those hospitals that shall be treated as sole community hospitals, as described in Section B1 of Chapter VI, shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient services during the rate period described in Section B.2.a of Chapter XVI:~~

~~[MATERIAL REMOVED]~~

~~a. The DRG PPS, as described in Chapters IV and VI, or~~

~~b. The rate calculated under Section A. of this Chapter.~~

~~10/93~~ ~~4. In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section B.2.a of Chapter XVI, but was subsequently reclassified by the Department as a rural hospital, as described in Section B.3 of Chapter XVI, on July 14, 1993, those hospitals that shall be treated as sole community hospitals, as described in Section B1of Chapter VI, shall elect one of the following payment methodologies to be used by the Department in reimbursing that hospital for inpatient admissions, or, if applicable, for inpatient services provided on October 1, 1993, and for the duration of the rate period described in Section B.2.a of Chapter XVI.:~~

~~10/93~~ ~~a. The DRG PPS, as described in Chapters IV and VII, or~~

~~10/93~~ ~~b. The rate calculated under Section A. of this Chapter.~~

07/14 ~~09/91~~ I. Reserved. ~~Annual Irrevocable Election~~

~~10/92~~ ~~1. The hospitals described in Sections H.2.and H.3.above, may elect to be reimbursed under the special arrangements described in Sections H.2 and H.3 above at the beginning of each rate period.~~

[MATERIAL REMOVED]

~~07/95~~ ~~2. Hospitals described in Sections H.2 through H4 above, may elect to be reimbursed under the special arrangements described in Sections H.2 through H.4.above effective with admissions, or, if applicable, with inpatient services provided, on October 1, 1993, and for the duration of the rate period described in Section B.2.a of Chapter XVI.~~

~~07/95~~ ~~3. Hospitals described in Section H.4.above may elect to be reimbursed under the special arrangements described in Section H.4.above at the beginning of each rate period described in Section B.2.b. of Chapter XVI.~~

~~10/93~~ ~~4. Once a sole community hospital elects to be reimbursed under the DRG PPS, it may not later in that rate period elect to be classified as exempt. Once a sole community hospital elects to be reimbursed as exempt, it may not later in that rate period elect to be reimbursed under the DRG PPS.~~

~~10/93~~ ~~5. Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care. Once such election has been made, the hospital may not later in that rate period elect to be reimbursed under any other methodology.~~

~~10/93~~ ~~6. Hospitals that, on August 31, 1991, had a contract with the Department under the Illinois Health Finance Reform Act and have elected to be reimbursed under the DRG PPS may not later elect to be reimbursed at rates stated in such contracts.~~

~~[MATERIAL REMOVED]~~

07/14 ~~10/92~~ J. Reserved.~~Notification of Reimbursement Methodology.~~

~~10/92~~ ~~1. Hospitals shall receive notification from the Department with respect to the reimbursement methodologies that shall be in effect for admissions occurring during the rate period.~~

~~10/93~~ ~~2. Hospitals described in Sections H.2 through H4 above shall receive notification of their reimbursement options accompanied by a Choice of Reimbursement form. Each hospital described in Sections H.2.through H.4 above shall have thirty (30) days from the date of such notification to file, with the Department, the reimbursement method of choice for the rate period. In the event the Department has not received the hospital's Choice of Reimbursement form within thirty (30) days from the date of notification, as described above, the hospital will automatically be reimbursed for the rate period under the reimbursement methodology that would have been in effect without benefit of the election described in Section I. above.~~

07/14 ~~09/91~~ K. Reserved.~~Pre-September 1, 1991 Admissions.~~

~~Reimbursement to hospitals for claims for admissions occurring prior to September 1, 1991, will be calculated and paid in accordance with the statutes, administrative rules, waivers, and state plans governing the time period when the services were rendered.~~

10/92 3. Prepayment Review

10/92 The Department may require hospitals to submit claims to the Department for prepayment review and approval prior to rendering payment for services provided. Such prepayment review requirements will be focused on areas where the Department has substantial reason to suspect abuse (e.g., hospital billings deviate from the norm). The review may be conducted by the Department or its' designated peer review agents. Prepayment review shall be used to determine the appropriateness and medical necessity of the inpatient stay. Payment shall not be made unless the medical necessity of the inpatient stay can be documented. The Department shall notify the hospital by letter or Department Informational Notice of the designated services, which shall be subject to prepayment review. The prepayment review requirement shall commence thirty- (30) days after the Department has given notice to the hospital of the designated services, which shall be reviewed.

10/92 4. Post-payment Review

10/92 Post-payment review shall be conducted on a random sample of hospital stays following reimbursement to the hospital for the care provided. The Department may also conduct post-payment review on specific types of care.

10/92 5. Hospital Utilization Control

10/93 Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991). Utilization control requirements for inpatient psychiatric hospital care in a psychiatric hospital, as defined in Chapter VII ~~Section C.1 of Chapter II~~ of this plan, shall be in accordance with federal regulations in 42 CFR, Ch. IV, Part 456, Subpart G (October 1, 1991).

10/93 7. Furnishing of Inpatient Hospital Services Directly or Under Other Arrangements

07/14 ~~07/95~~ a. The applicable payments made under this Attachment ~~Chapters VI, VIII, X., XIII, XIV and XVII~~ are payment in full for all inpatient hospital services other than for the services of non-hospital-based physicians to individual program participants and the services of certain hospital-based physicians as described below.

~~i. Hospital-based physicians who may not bill separately on a fee for service basis:~~

~~10/92 A. A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee for service basis.~~

~~10/92 B. A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.~~

~~ii. Hospital-based physicians who may bill separately on a fee-for-service basis:~~

~~10/92 A. A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.~~

~~10/92 B. A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.~~

~~10/92 C. A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.~~

~~10/92~~ ~~D. A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.~~

~~10/92~~ ~~E. A physician holding a non-teaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.~~

04/94 b. Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

09/91 M. Reductions to total payments~~, as described in Section E. of Chapter VII,~~ shall apply regarding co-payments and third party payments.

07/14 ~~07/97~~ N. Reserved. ~~All per diem payments calculated under Sections A, B, C, D, and F above, in effect on January 18, 1994, less the costs attributed to medical education, shall remain in effect hereafter.~~

07/14 ~~01/01~~ O. Notwithstanding the provisions set forth in Chapter VIII, effective July 1, 2014 ~~January 1, 2001~~payments for hospital inpatient services shall not exceed charges to the Department. This payment limitation shall not apply to county owned hospitals, large public hospitals, ~~or as described government owned or operated hospitals described in Chapter II.C.8,~~ or children's hospitals as described in Chapter VII ~~Chapter II.C.3~~. This payment limitation shall not apply to or affect disproportionate share payments as described in Chapter VI.C.7, payments for outlier costs as described in Chapter VIII F., or for payments for Medicaid High Volume Adjustments as described in Chapter VI.FJ.

IX. Review Procedure

07/14 Hospitals shall be notified of their rates for the rate year and shall have an opportunity to request a review, pursuant to subsection H. of this Chapter, of any rate for errors in calculation made by the Department.

07/14~~10/93~~ A. Reserved.~~Inpatient Rate Reviews. Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of their rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

07/14~~07/95~~ B. Reserved.~~Hospitals reimbursed in accordance with Chapter VIII, and Chapters IV and VII. With respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs which have been mandated in order to meet State, federal or local health and safety standards, and which have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be received, in writing, by the Department within 30 days after the date of the Department's notice to the hospital of their rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

07/14 ~~10/03~~ C. DSH and MPA Determination Reviews.

Hospitals shall be notified of their qualification for DSH or MPA payment adjustments and shall have an opportunity to request a review pursuant to subsection C.1. of this Chapter. ~~of the DSH add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of its DSH qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

07/14~~10/92~~

~~10/03~~

1. DSH or MPA determination reviews shall be limited to the following:

   a. DSH or MPA Determination Criteria. The criteria for DSH determination shall be in accordance with Section C. of Chapter VI. The criteria for MPA determination shall be in accordance with Chapter VI.G. ~~Section 148.122~~. Review shall be limited to verification that the Department utilized criteria in accordance with federal and State regulations.

   b. Medicaid Inpatient Utilization Rates.

      i. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section C.8.de. of Chapter VI. Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

07/14

ii Hospitals' Medicaid inpatient utilization rates, as defined in Section C.8.d.e, which have been derived from un-audited cost reports ~~or HDSC~~ forms, are not subject to the Review Procedure with the exception of errors in calculation by the Department. Pursuant to Section C.3.a.ii, of Chapter VI ~~C.3.a.iii.A), and C.3.a.iii.B)~~, hospitals shall have the opportunity to submit corrected information prior to the Department's final DSH or MPA determination.

c. Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and Section C.8.g. ~~s C.1.b. and C.4~~ of Chapter VI of this State Plan. Review shall be limited to verification that low- income utilization rates were calculated in accordance with federal and State regulations.

07/14~~10/03~~

d. Federally Designated Health Manpower Professional Shortage Areas (HMSA's~~HPSA's~~). Illinois hospitals located in federally designated HMSA's~~HPSA's~~ shall be identified in accordance with 42 CFR 5, 1989, and Section C.1.c. of Chapter VI. of this State Plan based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services ~~as of June 30, 1992.~~ Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSA's~~HPSA's~~ only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA's~~HPSA's as of June 30, 1992~~.

~~10/03~~ ~~e. Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 (89 Ill. Admin. Code, Section 148.120(a)(3) and 77 Ill. Admin. Code Section 1100) and Section C.1.e of Chapter VI of this State Plan based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and utilized by the Department was incorrect.~~

07/14~~10/03~~ e.~~f.~~ Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Sections G.1.h.iii.~~C.1.d., C.8.d., C.8.f., and C.8.g.~~ of Chapter VI. Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations

~~[MATERIAL REMOVED]~~

07/14 ~~D.~~ Reserved. ~~Outlier Adjustment Reviews. The Department shall make outlier adjustments to payment amounts in accordance with Chapter V or Section F. of Chapter VIII, whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

~~[MATERIAL REMOVED]~~

07/14 ~~07/95~~ E. Reserved. ~~Cost Report Reviews - Cost reports are required from: 1) all enrolled hospitals within the State of Illinois; 2) all out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and 3) all hospitals not located in Illinois that elect to be reimbursed under the DRG PPS. The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report, which may contain adjustments and revisions, which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis, which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

07/14 ~~07/95~~ F. Reserved. ~~Trauma Center Adjustment Reviews~~

~~07/95~~ ~~1. The Department shall make trauma care adjustments in accordance with Section E. of Chapter VI. Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation.~~

~~10/93~~ ~~2. Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.~~

~~10/93~~ ~~3. Appeals under this Section must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review~~

07/95 G. Medicaid High Volume Adjustment Reviews

The Department shall make Medicaid high volume adjustments in accordance with Section F. of Chapter VI. ~~Hospitals shall be notified of the Department's determination and have an opportunity to request a review, pursuant to subsection ?????. That review~~ Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

~~07/95~~ ~~H. Sole Community Hospital Designation Reviews~~

~~The Department shall make sole community hospital designations in accordance with Section B. of Chapter VI. Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

[MATERIAL REMOVED]

~~07/95~~ ~~I. Geographic Designation Reviews~~

~~07/95~~ ~~1. The Department shall make rural hospital designations in accordance with Section B.3 of Chapter XVI. Hospitals have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be made in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

~~2. The Department shall make urban hospital designations in accordance with Section B.4 of Chapter XVI. Hospitals have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be made in writing and must be received no later than 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.~~

~~7/02~~ ~~J. Safety Net Hospital Adjustment Payment Reviews~~

~~The Department shall make Safety Net Hospital Adjustment Payments in accordance with Section K of Chapter XV. Hospitals shall be notified in writing of the results of the Safety Net Hospital Adjustment Payments determination and calculation, and shall have the right to appeal the Safety Net Hospital Adjustment Payment calculation or their ineligibility for Safety Net Hospital Adjustment Payments if it is believed that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification of Safety Net Hospital Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Safety Net Hospital Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

07/14 H. Rate Review Requirements

1) All requests for review must be submittcd in writing and must either be received by the Department, or post marked within 30 days after the date of the Department's notice to the hospital. Such request shall include:

   A) a clear explanation of any suspected error,

   B) any additional documentation to be considered, and

   C) the desired corrective action. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) The review procedures provided for in this Section may not be used to submit any new or corrected information that was required to be submitted by a specific date in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposed will not be considered during the review process.

3) For purposes of this subsection, the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.

I. Medical Review Requirements: DRG Validation. The Department, or its agent, may require and perform pre-or-post-payment review of diagnosis and procedure codes to verify that the diagnostic and procedural coding, submitted by the hospital and used by the Department for DRG assignment, is substantiated by the corresponding medical records. The review may be undertaken by way of a sample of discharges. The review may, at the sole discretion of the Department, take place at the hospital or away from the hospital site.

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

[MATERIAL REMOVED]

~~07/97~~ ~~K. Critical Hospital Adjustment Payment (CHAP) Reviews~~

~~07/97~~ ~~1. The Department shall make CHAP payments in accordance with Chapter XV. Hospitals shall be notified in writing the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~07/95~~ ~~2. CHAP determination reviews shall be limited to the following:~~

~~07/95~~ ~~a. Federally Designated Health Professional Shortage Areas (HPSAs).~~

~~Illinois hospitals located in federally designated HPSAs shall be identified in accordance with 42 CFR 5, and Section A.3.b and B.3 of Chapter XV based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.~~

[MATERIAL REMOVED]

~~07/95~~ ~~b. Trauma level Designation~~

~~Trauma level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.~~

~~07/95~~ ~~c. Accreditation of Rehabilitation Facilities~~

~~Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.~~

~~07/95~~ ~~d. Medicaid Inpatient Utilization Rates~~

~~Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section C.8.e of Chapter VI. Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.~~

~~07/95~~ ~~e. Perinatal level designation~~

~~Perinatal level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.~~

[MATERIAL REMOVED]

~~f. Disproportionate share eligibility~~

~~Disproportionate share eligibility shall be determined pursuant to Section C. of Chapter VI. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.~~

~~07/95~~ ~~g. Occupancy Ratio~~

~~The occupancy ratio shall be obtained from the Illinois Department of Public Health's published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois" as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.~~

~~07/95~~ ~~h. Graduate Medical Education Programs~~

~~Graduate Medical Education program shall be obtained from the most recently published report of the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the above, substantiating that the information supplied to and utilized by the Department was incorrect.~~

[MATERIAL REMOVED]

~~L. Tertiary Care Adjustment Payment Reviews.~~

~~The Department shall make Tertiary Care adjustment payments in accordance with Chapter XV, Section L. Hospitals shall be notified in writing of the results of the Tertiary Care Adjustment Payments determination and calculation, and shall have the right to appeal the Tertiary Care Adjustment Payments calculation or their ineligibility for Tertiary Care Adjustment Payments, if it is believed that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Tertiary Care Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Tertiary Care Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

[MATERIAL REMOVED]

~~M. Psychiatric Adjustment Payment Reviews~~

~~The Department shall make Psychiatric Adjustment Payments in accordance with Chapter XV, Section M. Hospitals shall be notified in writing of the results of the Psychiatric Adjustment Payments determination and calculation, and shall have a right to appeal the Psychiatric Adjustment Payments calculation or their ineligibility for Psychiatric Adjustment Payments if it is believed that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Psychiatric Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for Psychiatric Adjustment Payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~N. Rural Adjustment Payment Reviews~~

~~The Department shall make Rural Adjustment Payments in accordance with Chapter XV, Section N.~~

~~1. Hospitals shall be notified in writing of the results of the Rural Adjustment Payments determination and calculation, and shall have a right to appeal the Rural Adjustment Payments calculation or their ineligibility for Rural Adjustment Payments if it is believed that a technical error has been made in the calculation by the Department.~~

~~2. The designation of Critical Access Provider and Necessary providers is obtained from the Illinois Department of Public Health as of the first day of July proceeding the rural adjustment payment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.~~

~~3. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification for Rural Adjustment Payments and payment adjustment amounts, or a letter of notification that the hospital does not qualify for~~

[MATERIAL REMOVED]

~~Rural Adjustment Payments.~~

~~Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~O. Pediatric Inpatient Adjustment Payments. The Department shall make Pediatric Inpatient Adjustment payments in accordance with Chapter XX. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for payments under Section 148.298 if it is believed that a technical error has been made in the calculation by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital of its qualification under Section 148.298 and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.~~

~~P. For purposes of this Section, the term "post marked" means the date of processing by the United States Post Office or any independent carrier service.~~

~~Q. The review procedures provided for in this Section may not be used to submit any new or corrected information that was required to be submitted by a specific date in order to qualify for a payment or payment adjustment. In addition, only information that was submitted expressly for the purpose of qualifying for the payment , or payment adjustment under review shall be considered by the Department. Information that has been submitted to the Department for other purposes will not be considered during the review process.~~

[MATERIAL REMOVED]

~~R. Psychiatric Base Rate Payment Adjustments Reviews. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for Psychiatric Base Rate Payment Adjustments under Chapter XXI. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

~~S. High Volume Adjustment Payment Reviews. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for High Volume Adjustment Payments under Chapter XXII. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

~~T. Supplemental Tertiary Care Adjustment Payment Reviews. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for Supplemental Tertiary Care Adjustment Payments under Chapter XXIII. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

~~U. Medicaid Inpatient Utilization Rate Adjustment Reviews. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for MIUR Adjustment payments under Chapter XXIV. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

~~[MATERIAL REMOVED]~~

07/14 X. Transplant Care Prior to July 1, 2014

A. Hospital services rendered for transplant procedures (with the exception of kidney and cornea transplants which are reimbursed in accordance with Chapters IV. and VII, Chapter VIII, Chapter XIII, or Chapter XIV, as applicable) under this Section are exempt from the provisions of Chapters IV, VII, VIII, XIII, and XIV, of this State Plan. Hospital reimbursement for transplants covered within this Section is an all-inclusive rate for the admission, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for the number of days listed below for specific types of transplants:

1. A maximum 30 consecutive days of postoperative inpatient care for heart, heart/lung, lung (single or double), pancreas or kidney/pancreas transplant; or
2. 40 consecutive days of inpatient care for liver transplant; or
3. 50 consecutive days for inpatient care for bone marrow transplant, this includes a maximum of seven days prior to transplant for infusion of chemotherapy), or 50 consecutive days of care for an inpatient or outpatient stem cell transplant;
4. 70 consecutive days of postoperative inpatient care for intestinal (small bowel or liver/small bowel) transplants
5. For other types of transplants covered when, a hospital has been certified by the Department, the number of consecutive days of inpatient care specified within the transplant certification process
6. Applicable disproportionate share payment adjustments shall be made in accordance with Section C.7 of Chapter VI. Applicable outlier adjustments shall be made in accordance with Section F. of Chapter VIII. Applicable specific inpatient payment adjustments shall be made in accordance with Chapter VI

08/01 B. The Department will cover organ transplants identified as covered service provided to United States citizens or aliens permanently residing in the United States under color of law pursuant to 42 U.S.C. 1396a(a) and 1396b(v) and provided by certified organ transplant centers; meets the Department's certification requirements including, but not limited to, completion and submission of the required application, patient selection criteria and detailed status reports for all transplants.

The certified transplant center will be determining the medical necessity and appropriateness of transplant procedures but must notify the Department prior to performance of the transplant procedure.

XI. Hospital- Residing Long Term Care

10/93 A. Long term care services are not considered by the Department to be hospital services unless the hospital is enrolled with the Department specifically to provide hospital residing long term care services as a hospital-based long term care facility. Hospital residing long term care is care provided by hospitals to non-acute patients requiring chronic, skilled nursing care when a skilled nursing facility bed is not available, or non-acute care provided by hospitals that is not routinely performed within a skilled setting, such as ventilator care, when appropriate placements are not available to discharge the patient. Hospitals may not utilize the following beds or facilities for hospital services unless the hospital is enrolled with the Department to provide hospital residing long-term care:

1. A special unit or specified beds which are certified for skilled nursing facility services under the Medicare Program; or

2. A special unit or separate facility administratively associated with the hospital and licensed as a long- term care facility.

B. There are three categories of service for hospital residing long- term care. These categories are as follows:

1. Skilled Care - Hospital Residing (category of service 037). Reimbursement is available for hospitals providing hospital residing long- term care when the patients' needs reflect routine skilled care and the inability to place the patient is due to unavailability of a skilled nursing bed. Reimbursement for this type of care is at the average statewide rate for skilled nursing care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

   a. The hospital must document its attempt to place the patient in at least five appropriate facilities.

   b. Documentation (formHFS ~~DPA~~ 3127) must be attached to the appropriate claim form and submitted to the Department.

   c. Reimbursement is limited to services provided after the minimum number of contacts has been made. Reimbursement will not be made for services, which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement may ~~will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement

2. Exceptional Care Hospital Residing (category of service 038). Reimbursement is available for hospitals providing hospital residing long- term care when the level of care is not routinely performed within a skilled setting, such as ventilator care, and the patient cannot be placed in a skilled nursing facility because the level of care is not available. Exceptional care is defined by the Department as the level of care required by persons who are medically stable and ready for discharge from a hospital but who require a multi-disciplinary level of care for physician, nurse, and ancillary specialist services with exceptional costs related to extraordinary equipment and supplies that have been determined to be a medical necessity. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or a related condition, head injured persons, and ventilator dependent persons. Reimbursement for this type of care is at the average statewide rate for exceptional care. For a hospital to be eligible for such reimbursement, the following criteria must be met:

   a. The hospital must document its attempt to place the patient in at least five appropriate facilities.

   b. Documentation (form HFS ~~DPA~~ 3127) must be attached to the appropriate claim form and submitted to the Department.

   c. Reimbursement is limited to services provided after the minimum number of contacts has been made. Reimbursement will not be made for services, which were billed as acute inpatient care and denied as not being medically necessary. Reimbursement may ~~will~~ be made for up to a maximum of 31 days before additional documentation must be submitted to extend the eligibility for additional reimbursement.

3. ID~~DD~~/MI Non-Acute Care - Hospital Residing (category of service 039). Reimbursement is available for hospitals providing hospital residing long- term care when the preadmission screening agent has not completed the assessment, planning or discharge process. Reimbursement for this type of care is at the average statewide ~~DD/MI~~ rate for intermediate care facilities for persons with intellectual disabilities. For a hospital to be eligible for such reimbursement, the following criteria must be met:

   a. The hospital must document that the preadmission screening agent has not completed the assessment, planning or discharge process.

~~[MATERIAL REMOVED]~~

07/14 XII. Alternatives Prior to July 1,2014

All provisions of Chapters I through XII of this Plan shall be in effect during the fiscal year for so long as the Director of the Department finds that:

09/91 A. The total number of hospitals agreeing to be reimbursed pursuant to the provisions of this state plan is sufficient to assure that medical assistance recipients have reasonable access to hospital services. In making this determination, factors considered by the Department include but are not limited to service availability and the number of recipients within a geographic area, recipient travel time to obtain services, and availability of a range of services within a geographic area.

09/91 B. The provisions are approved by the Department of Health and Human Services through the approval of this State Title XIX Plan.

~~XII. Adjustments and Reductions to Total Payments~~

~~A. The adjustments described in this Section, as applicable, shall be made to reimbursement amounts calculated pursuant to Sections 148.105, 148.110, 148.115, 148.140, 148.160, 148.170, 148.330 and 89 Ill. Adm. Code 149.100 prior to payment. The adjustments are to be applied in the order in which they are listed in this Section.~~

~~B. Adjustments to base rates made pursuant to 89 Ill. Adm. Code 152.150.~~

~~C. Increases in payments. Supplemental payments pursuant to the Long Term Acute Care Hospital Quality Improvement Transfer Program Act [210 ILCS 155] in accordance with Section 148.115(f).~~

~~D. Reductions in payments. The Department's payment obligation shall be reduced by:~~

~~1. Charges. Except for reimbursement calculated under Sections 148.140, 148.160, and 148.170, payment shall not exceed the lesser of:~~

~~a. The reimbursement amount determined pursuant subsections (a) and (b).~~

~~b. The allowable charges billed to the Department on the claim.~~

~~2. Hospital Rate Reductions. Payment shall be reduced pursuant to the provisions of 89 Ill. Adm. Code 152.100~~

~~3. Third part liability. Hospitals shall determine whether services are covered, in whole or in part, under any program or under any other private group indemnification or insurance program, or managed care entity. To the extent that such coverage is available, the Department's payment obligation shall be reduced.~~

~~4. Copayments. Copayments are assessed in accordance with Section 148.190.~~

~~E. Increases in payments. The Department's payments obligations shall be increased, if applicable, by:~~

~~1. Medicaid high volume adjustment payments pursuant to Section 148.112.~~

~~2. Medicaid percentage adjustment payments pursuant to Section 148.122.~~

~~3. Disproportionate share hospital adjustment payments pursuant to Section 148.120.~~

~~[MATERIAL REMOVED]~~

XIII. County-Owned Hospitals in a County with a Population of Over 3 Million Prior to July 1, 2014

07/95 A. Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million.

10/92 In accordance with Section C.8.of Chapter II, county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this Section.

10/93~~07/91~~ B. Base Year Costs

~~10/93~~ 1. The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 *CFR* 447.260 and 447.265 (1982)) for hospitals' fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.

~~10/93~~ 2. The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in Section B.1.above.

~~10/93~~ 3. The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in Section B.1.above.

~~10/93~~ 4. The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in Sections B.1 through B.3 above.

~~10/93~~ 5. New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in Section B.4.above and inflated in Section D.1 below.

10/93 C. Restructuring Adjustment. Adjustments to the base year cost per diem, as described in Section B.4 above, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 *CFR* Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, *i.e.*, on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports

~~[MATERIAL REMOVED]~~

received at the Office of Health Finance, Illinois Department of Public Aid, between the first and the fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of the national total hospital market basket price proxies, (DRI), and added to the base year cost per diem, as described in Section B.4.above, which is subject to the inflation adjustment described in Section D. below.

07/92 D. Inflation Adjustment For Base Year Cost Report Inflator

10/93 1. The base year cost per diem, as defined in Section B.4 above, shall be inflated from the midpoint of the hospital's base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in Section B.1 above by the previous year's operating cost per diem.

07/03 2. Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.

07/03 3. Effective July 1, 2003, the rate for hospital inpatient services shall be the rate calculated in accordance with subsections (D)(1) and (2) of this Section, that was in effect on January 1, 2003. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 *CFR* 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the *Social Security Act*. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section

07/91 E. Review Procedure

The review procedure shall be in accordance with Chapter IX.

07/95 F. Applicable Inpatient Adjustments

07/95 1. The criteria and methodology for making applicable DSH adjustments to hospitals, which are exempt from the DRG PPS as described in Section C.8 of Chapter II, shall be in accordance with Section C.7.a of Chapter VI.

07/95 2. The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals, which are exempt from the DRG PPS as described in Section C.8 of Chapter II, is described below.

~~[MATERIAL REMOVED]~~

07/95 a. The payment adjustment shall be $150 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate as described in Section C.7.e of Chapter VI, exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate as defined in Section C.7.c. of Chapter VI multiplied by 3.75. This payment adjustment is based on a rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.

07/95 b. The amount calculated pursuant to Section F.2 a above shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:

07/95 i. The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

07/95 ii. The percentage increase in the statewide average hospital payment rate, as described in Section C.8.h. of Chapter VI, over the previous year's statewide average hospital payment rate.

07/03 c. The amount calculated pursuant to Sections F.2.a through F.2.b. above shall be no less than the rate calculated in accordance with Section C.7.b. of Chapter VI in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year, through July 1 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

07/03 d. Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 *CFR* 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section.

07/95 e. The amount calculated pursuant to Section F.2. of this Chapter, shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

07/96 3. County Provider Adjustment

a. Effective July 1, 1995, hospitals reimbursed under this Chapter shall be eligible to receive a county provider adjustment. The methodology used to determine the add-on payment amount is as follows:

07/96 i. Beginning with July 1, 1995, hospitals under this Chapter shall receive $15,500 per Medicaid inpatient admission in the base period.

~~[MATERIAL REMOVED]~~

07/03 ii. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 *CFR* 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the *Social Security Act*. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments if there is allowable room under the State's federal DSH allotment, as determined in Section 1923(f) of the *Social Security Act*, and under the hospital specific OBRA test, which is conducted to ensure compliance with Section 1923(g) of the *Social Security Act*. The amount of the payment that will be classified as DSH will be determined in the following manner:

1. One-half of this quarterly payment will be classified as DSH spending for federal reporting purposes.
2. If the federal upper payment limit cap reduces spending by an amount that is greater than one-half of the quarterly spending, the amount reclassified as DSH will be increased by the amount of the payment reduction that exceeded one-half of the original payment.
3. The amount classified as DSH spending in subsections (1) or (2) will be constrained both by the available funding in the State's federal DSH allotment, and the hospital specific OBRA test.

iii. The payments made under this subsection shall be made on a quarterly basis.

b. County Provider Adjustment Definitions

07/96 i. "Base Period" means State fiscal year 1994.

07/96 ii. "Medicaid Inpatient Admission" means hospital inpatient admissions provided in the base period, which were subsequently adjudicated by the Department through the last day of June, 1995, for recipients of medical assistance under Title XIX of the *Social Security Act*, excluding admissions for normal newborns and Medicare/Medicaid crossover days.

07/03 4. Hospitals reimbursed under this Chapter shall receive supplemental inpatient payments. Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in Section B.4. above, as adjusted for restructuring, as described in Section C. above, and as adjusted for inflation, as described in Section D. above, and the calculated Medicaid percentage per diem payment adjustment, as described in Section F.2. of this Chapter, by the hospital's percentage of inpatient charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective July 1, 1995, the supplemental inpatient payments calculated under this subsection shall be no less than the supplemental inpatient rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, through July 1, 2002, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days. Effective July 1, 2003, the supplemental inpatient rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. Effective July 1, 2003, the Medicaid Percentage Adjustment rate for hospital inpatient services shall be the rate that was in effect on January 1, 2003. The minimum may be adjusted by the Department to ensure compliance with aggregate Upper Payment limitation requirements at 42 CFR 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923 (g) of the Social Security Act. Rate adjustments will be conducted in accordance with subsection (I)(3) of this Section. The supplemental inpatient payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

G. Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section F. of Chapter III.

H. Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section E. of Chapter VI.

~~[MATERIAL REMOVED]~~

10/92 I. Reductions to Total Payments

1. Co-payments

   Co-payments are assessed under all medical programs administered by the Department and shall be assessed in accordance with Section E.1 of Chapter VII.

2. Third Party Payments

   The requirements of Section E.2.of Chapter VII shall apply.

07/03 3. If, during the Department's analysis of the aggregate upper payment limit test, or the hospital specific OBRA test for DSH hospitals, the Department determines that payments described in subsections (D) and (F) of this section, as well as Chapter XV subsection (D)(8), exceed the allowable limits, the Department will make the following payment adjustments:

   a. Inpatient payments in Chapter XV subsection (D)(8) will be reduced until total payments no longer exceed the federal UPL and OBRA spending limits.

   b. If payments, reduced under subsection (a), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (F)(3) of this Section will be reduced until total payments no longer exceed the federal UPL and OBRA spending limits.

   c. If payments, reduced under subsection (b), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (F)(4) of this Section will be reduced until total payments no longer exceed the federal UPL spending limit

~~[MATERIAL REMOVED]~~

d. If payments, reduced under subsection (c), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (F)(2)(d) of this Section will be reduced until total payments no longer exceed the federal UPL spending limit.

e. If payments, reduced under subsection (d), reach zero and the state is still out of compliance with the federal spending limits, payments from subsection (D) of this Section will be reduced until total payments no longer exceed the federal UPL spending limit.

10/92 J. Pre-payment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section L. of Chapter VIII.

10/92 K. Cost Reporting Requirements

Cost reporting requirements shall be in accordance with Section G. of Chapter VIII.

~~[MATERIAL REMOVED]~~

07/14 XIV. Hospitals Organized Under the University of Illinois Hospital Act Prior to July 1, 2014

10/93 A. Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act

In accordance with Section C.8 of Chapter II, hospitals organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS and shall be reimbursed in accordance with this Section.

09/91 B. Base Year Costs

07/95 1. Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982) for hospitals' fiscal year 1992.

2. For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

10/92 C. Restructuring Adjustment

Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received.

~~[MATERIAL REMOVED]~~

Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of the national total hospital market basket price proxies, (DRI), and added to the base year costs.

10/93 D. Inflation Adjustment For Base Year Cost Report Inflator

Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.

09/91 E. Review Procedure

The review procedure shall be in accordance with Chapter IX.

10/93 F. Applicable adjustments for DSH Hospitals

10/93 1. The criteria and methodology for making applicable adjustments to DSH hospitals, which are exempt from the DRG PPS as described in Chapter II, shall be in accordance with Section C.7 of Chapter VI.

2. Effective October 1, 1993, in addition to the DSH payment adjustments described in Section C.7 of Chapter VI, hospitals reimbursed under this Chapter shall receive supplemental DSH payments. Effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Chapter shall be calculated by multiplying the sum of the hospital's base year costs, as described in Section B. above, as adjusted for restructuring, as described in Section C. above, and as adjusted for inflation, as described in Section D. above, and the calculated disproportionate share per diem payment adjustment as described in Section C.7.of Chapter VI, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50, and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

09/91 G. Outlier Adjustments

Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section F. of Chapter VIII.

~~[MATERIAL REMOVED]~~

09/91 H. Reduction to Total Payment

1. Co-payments. Co-payments are assessed under all medical programs administered by the Department and shall be assessed in accordance with Section E.1 of Chapter VII.

2. Third - Party Payments

07/95 The requirements of Section E.2 of Chapter VII shall apply.

09/91 I. Pre-payment and Utilization Review

Prepayment and utilization review requirements shall be in accordance with Section L. of Chapter VIII.

09/91 J. Cost Reporting Requirements

Cost reporting requirements shall be in accordance with Section G. of Chapter VIII.

07/95 K Rate Period

The rate period for hospitals reimbursed under this Chapter shall be the 12- month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of July 1, 1995, through September 30, 1995.

10/02 XV. Critical Hospital Adjustment Payments (CHAP)

07/14 Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Chapter XVI A.1.a.i, ~~unless otherwise noted in this Chapter XV, and hospitals organized under the University of Illinois Hospital Act, as described in Chapter XVI A.1.a.ii.~~for inpatient admissions occurring on or after July 1, 1998, in accordance with this Chapter. For a hospital that is located in a geographic area of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 ILCS 5/5-30 no new payment or rate increase that would otherwise become effective for dates of service on or after July 1, 2010 shall take effect under this Section unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in subsection H.5.~~(g)(5)~~ of this Section no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care Program.

07/14 ~~07/07~~ A. Reserved.~~Trauma Center Adjustments (TCA)~~

~~The Department shall make a trauma center adjustment (TCA) to Illinois hospitals recognized as a Level I or Level II trauma center by the Illinois Department of Public Health (IDPH), in accordance with the provisions of 1 through 4 of this Chapter. For purposes of a TCA, a children's hospital, as defined under Section II.C.3., operating under the same license as a hospital designated as a trauma center shall be deemed to be a trauma center.~~

~~1. Level I Trauma Center Adjustment (TCA).~~

~~a. Criteria. Illinois hospitals that, on the first day of July in the CHAP rate period are recognized as a Level I trauma center by the IDPH shall receive the Level I trauma center adjustment. Hospitals qualifying under subsection A.2. are not eligible for payment under this subsection.~~

~~b. Adjustment. Illinois hospitals meeting the criteria specified in 1.a. of this Chapter shall receive an adjustment as follows:~~

~~i. Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under 1.a. of this Chapter shall receive an adjustment of $21,365.00 per Medicaid trauma admission in the CHAP base period.~~

~~ii. Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under 1.a. of this Chapter shall receive an adjustment of $14,165.00 per Medicaid trauma admission in the CHAP base period.~~

~~07/07~~ ~~2. Level I Trauma Center Adjustment for Illinois hospitals located in the same city, that alternate their Level I trauma center designation.~~

~~a. Criteria. Illinois hospitals that are located in the same city and participate in an agreement in effect as of July 1, 2007, whereby their designation as a Level I trauma center by the Illinois Department of Public Health is rotated among qualifying hospitals from year to year or during a year, that are in the following classes:~~

~~i. A children's hospital – All children's hospitals as defined in II.C.3., in a given city, qualifying under subsection A.2.a. shall be considered one entity for the purposes of calculating the adjustment in subsection A.2.b.~~

~~ii. A general acute care hospital – All general acute care adult hospitals, in a given city, affiliated with a children's hospital, as defined in subsection A.2.a.i., qualifying under subsection A.2.a., shall be considered one entity for the purposes of calculating the adjustment in subsection A.2.b.~~

~~b. Adjustment. Hospitals meeting the criteria specified in subsection A.2.a., shall receive an adjustment as follows:~~

~~[MATERIAL REMOVED]~~

~~i. If the sum of Medicaid trauma center admissions within either class, as described in subsection A.2.a., is equal to or greater than the mean Medicaid trauma admissions for the 2 classes under subsection A.2.a., of this Section, then each member of that class shall receive an adjustment of $5,250.00 per Medicaid trauma admission for that class, in the CHAP base period.~~

~~ii. If the sum of Medicaid trauma center admissions within either class, as described in subsection A.2.a., is less than the mean Medicaid trauma admissions of the 2 classes under subsection A.2.a., of this Section, then each member of that class shall receive an adjustment of $3,625.00 per Medicaid trauma admission for that class, in the CHAP base period.~~

~~07/07~~ ~~3. Level II Rural Trauma Center Adjustment (TCA). Illinois rural hospitals, as defined in Chapter XVI B.3, that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period.~~

~~07/07~~ ~~4. Level II Urban Trauma Center Adjustment (TCA). Illinois urban hospitals, as described in Chapter XVI B.4, that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health (IDPH) shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the following criteria:~~

~~a. The hospital is located in a county with no Level I trauma center;~~

~~b. The hospital is located in a Health Professional Shortage Area, as of the first day of July in the CHAP rate period and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in A.4.a of this Chapter or the hospital has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection A.4.a of this Chapter; and~~

~~c. The hospital does not qualify under subsection A.2.~~

~~5. In determining payments that are pursuant to the Trauma Center Adjustments as described in this Section , for the CHAO rate period occurring in State fiscal year 2009, total payments will equal the methodologies described in this Section. For the period December 1, 2008 to June 30, 2009, payment will equal the State Fiscal year 2009 amount less the amount the hospital received for the period July 1, 2008 to Novermber 30, 2008.~~

B. Reserved.~~Rehabilitation Hospital Adjustment (RHA)~~

~~01/11~~ ~~Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as free-standing acute comprehensive rehabilitation hospitals, as defined Section C.2 of Chapter II, and are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare Facilities), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following four components:~~

~~07/02~~ ~~1. Treatment Component. All hospitals defined in Section B. of this Chapter shall receive $4,215.00 per Medicaid Level I rehabilitation admission in the CHAP base period.~~

~~2. Facility Component. All hospitals defined in Section B. of this Chapter shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:~~

~~07/05~~ ~~a. Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $229,360.00 in the CHAP rate period~~

~~b. Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $527,528.00 in the CHAP rate perio~~

~~07/02~~ ~~3. Health Professional Shortage Area Adjustment Component. Hospitals defined in Section B. of this Chapter, that are located in an HPSA as of the first day of July in the CHAP rate period, shall receive $276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.~~

~~01/11~~ ~~4. Magnet Facility Component. Hospitals defined in subsection B. of this Chapter that as of July 1, 2010, are designated as a "magnet hospital" by the American Nurses' Credentialing Center, will receive a magnet component of $1,500,000 for the period January 1, 2011 through June 30, 2011, and $1,500,000 for the period July 1, 2011 through June 30, 2012.~~

C. Direct Hospital Adjustment (DHA) Criteria

1. Qualifying Criteria

07/06 Hospitals may qualify for the DHA under this subsection under the following categories, unless the hospital did not provide Comprehensive emergency treatment services ~~as defined in subsection K 5(C) below~~, on or after July 1, 2006, but did provide such services on January 1, 2006, unless the hospital provider operates within 1 mile of an affiliate hospital provider, that is owned and controlled by the same governing body that operates a comprehensive emergency room and the provider operates a standby emergency room that functions as an overflow emergency room for its affiliate hospital provider.

a. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals and long term stay hospitals, all other hospitals located in Health Service Area (HSA) 6 that either:

i. Were eligible for Direct Hospital Adjustments under the CHAP program as of July 1, 1999, and had a Medicaid inpatient utilization rate (MIUR) equal to or greater than the statewide mean in Illinois on July 1, 1999;

ii. Were eligible under the Supplemental Critical Hospital Adjustment Payment (SCHAP) program as of July 1, 1999, and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii. Were county-owned hospitals as defined in Chapter VII ~~Section C.8 of Chapter II~~, and had a MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

b. Illinois Hospitals located outside of HSA 6 that have a MIUR greater than 60 percent on July 1, 1999, and an average length of stay less than ten days. The following hospitals are excluded from qualifying from this criteria: children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

c. Children's hospitals, as defined under Section II.C.3, on July 1, 1999.

d. Illinois Teaching hospitals with more than 40 graduate medical education programs, on July 1, 1999, not qualifying in subsections C.1.a, b. or c. of this Chapter.

~~e. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsections (C)(1)(a),(b),(c) or (d) above, all other hospitals located in Illinois that had a MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999, and provided more than 15,000 total days.~~

~~f. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections (C)(1)(a),(b),(c),(d) or (e) all other hospitals that had a MIUR greater than 40 percent on July 1, 1999, and provided more than 7,500 total days and provided obstetrical care as of July 1, 2001.~~

~~10/03~~ ~~g. Illinois teaching hospitals with 25 or more graduate medical programs on July 1, 1999, that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the *Alzheimer's Disease Assistance Act* [410 *ILCS* 405/4], that has an MIUR less than 25 percent on July 1, 1999, and provided 75 or more Alzheimer days for patients diagnosed as having the disease.~~

~~10/03~~ ~~h. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection C (1)(a) through C(1)(g) of this section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.~~

01/06 ~~c~~i. Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsections C.1.a through C.1.d. ~~(C)(1)(a) through (C)(1)(h)~~, all other hospitals that had a MIUR greater than 23 percent on July 1, 1999, an average length of stay less than four days, provided more than 4,200 Total days and provided 100 or more Alzheimer days for patients diagnosed as having the disease.

D. DHA Rates and Payments

07/14 ~~07/02~~ 1. For hospitals qualifying under subsection C.1.a above, that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will continue to receive the rate in effect as of December 31, 2013, $105.00 per day for hospitals that do not provide obstetrical care and a rate of $142.00 per day for hospitals that do provide obstetrical care, for dates of service through June 30, 2014. For dates of service on or after July 1, 2014, the rate is $0.00.~~the DHA rates are as follows:~~

~~a. Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $69.00 per day for hospitals that do not provide obstetrical care and $105.00 per day for hospitals that do provide obstetrical care.~~

~~b. Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviations above the Statewide mean Combined MIUR, will receive $105.00 per day for hospitals that do not provide obstetrical care and $142.00 per day for hospitals that do provide obstetrical care.~~

~~c. Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviations above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.~~

~~d. Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.~~

07/14 ~~04/05~~ 2. Hospitals qualifying under subsection C.1.a. of this Chapter with an average length of stay less than 3.9 days will continue to receive the rate in effect as of December 31, 2013, $254.00 per day.~~, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00 will also receive the following rates:~~

~~a. County-owned hospitals as defined in Section C.8 of Chapter II, with more 30,000 Total days will have their rate increased by $455.00 per day.~~

~~04/09~~ ~~b. Hospitals that are not a county owned with more than 30,000 total days will have their rate increased by $354.00 per day for dates of service on or after April 1, 2009.~~

~~c. Hospitals with more than 80,000 Total days will have their rate increased by an additional $423.00 per day.~~

~~d. Hospitals with more than 4,500 Obstetrical days will have their rate increased by $101.00 per day.~~

~~e. Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional $194.00 per day.~~

~~f. Hospitals with an MIUR rate greater than 74 percent will have their rate increased by $147.00 per day.~~

~~07/12~~ ~~g. Hospitals with an average length of stay less than 3.9 days will have their rate increased by $385.00 per day through December 31, 2014 June 30, 2012. For dates of service on or after January 1, 2015 July 1, 2012, the rate is $131.00.~~

~~04/09~~ ~~h. Hospitals with a MUIR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999, will have their rate increased by $360.00 per day for dates of service on or after April 1, 2009.~~

~~04/09~~ ~~i. Hospitals receiving payments under subsection (D)(1)(b) that have an average length of stay less than 4 days will have their rate increased by $650.00 per day for dates of service on or after April 1, 2009.~~

~~07/06~~ ~~j. Hospitals receiving payments under subsection (D)(1) that have a MIUR greater than 60 percent will have their rate increased by $320.50 per day.~~

~~04/09~~ ~~k. Hospitals receiving payments under subsection (D)(1)(d) that have a Medicaid inpatient utilization rate greater than 70 percent and have more than 20,000 days will have their rate increased by $185.00 per day for dates of service on or after April 1, 2009.~~

~~07/06~~ ~~l. Hospitals with a Combined MIUR greater than 75 percent, that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate increased by $148.00 per day.~~

07/14 3. Hospitals receiving payments under subsection C.1.a. ~~(a)(2)(A)~~ of this Section that have an average length of stay less than four days will continue to have their rate increased by $650.00 per day for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by $1,040 per day. For dates of service on or after July 1, 2014, the rate is $0.00. ~~Hospitals qualifying under subsection C.1.b. of this Chapter will receive the following rates:~~

~~a. Qualifying hospitals will receive a rate of $421.00 per day.~~

~~07/12~~ ~~b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by $824.00 per day through December 31, 2014 June 30, 2012. For dates of service on or after January 1, 2015 July 1, 2012, the rate is $369.00.~~

07/14 ~~07/02~~ 4. Hospitals with a Combined MIUR greater than 75 percent that have more than 20,000 total days, have an average length of stay less than five days and have at least one graduate medical program will have their rate continue to be increased by $148.00 per diem for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is increased by $287.00 per day. For dates of service on or after July 1, 2014, the rate is $0.00. ~~Hospitals qualifying under subsection C.1.c. of this Chapter will receive the following rates:~~

~~a. Hospitals will receive a rate of $28.00 per day.~~

~~b. Hospitals located in Illinois and outside of HSA 6 that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $55.00 per day.~~

STATE PLAN UNDER TITLE XIX OF THE *SOCIAL SECURITY ACT*

State: **Illinois**

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

~~07/12~~ ~~e. Hospitals located in Illinois and inside HSA 6 that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by $573.00 per day. For dates of service on or after January 1, 2011 through December 31, 2014June 30, 2012, this rate shall be increased by an additional $47.00 to $620.00 per day.~~

~~07/12~~ ~~d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by:~~

~~i. $32.00 per day for hospitals that have less than 4,000 total days; or~~

~~ii. $363.00 per day for dates of service through December 31, 2014June 30, 2012, for hospitals that have greater than 4,000 total days but less than 8,000 total days; for dates of service on or after January 1, 2015July 1, 2012, the increase is $246.00 per day; or~~

~~iii. $295.00 per day for dates of service through December 31, 2014June 30, 2012, for hospitals that have greater than 8,000 total days; for dates of service on or after January 1, 2015July 1, 2012, the increase is $178.00 per day.~~

~~01/06~~ ~~e. Hospitals with more than 3,200 Total admissions will have their rate increased by $328.00 per day.~~

07/14 5. Hospitals qualifying under subsection C.1.b.~~d.~~ of this Section that have more than 1,500 obstetrical days will continue to receive the rate in effect as of December 31, 2013, $224.00 per day.~~, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00. will receive the following rates:~~

~~07/02~~ ~~a. Hospitals will receive a rate of $41.00 per day.~~

~~b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.~~

~~04/09~~ ~~c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $191.00 per day for dates of service on or after April 1, 2009.~~

~~07/12~~ ~~d. Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rates increased by an additional $41.00 per day. For dates of service on or after January 1, 2011 through December 31, 2014June 30, 2012, this rate shall be further increased by $54.00 per day to $95.00 per day.~~

07/14 ~~07/05~~ 6. Hospitals qualifying under subsection C.1.c. ~~C1.e~~ above that are not located in Illinois, have an MIUR greater than 45 percent, and greater than 4,000 days, will continue to receive the rate in effect as of December 31, 2013, $117.00 per day.~~, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00. will receive $188.00 per day.~~

07/14 7. Hospitals qualifying under subsection C.1.d. of this Section with a combined MIUR that is equal to or greater than 35 percent will receive a rate of $54.00 per day.

07/14 8. Hospitals qualifying under subsection C.1.e. ~~(a)(1)(D)~~ of this Section will continue to receive the rate in effect as of December 31, 2013, $90.00 per day.~~, through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of $55.00 per day.~~

~~12/08~~ ~~8. Hospitals that qualify under subsection(c)(1)(G) of this Section will receive the following rates:~~

~~a. Hospitals with an MIUR equal to or less than 19.75 percent will receive a rate of $11.00 per day.~~

~~b. Hospitals with an MIUR greater than 19.75 but equal to or less than 20.00 percent will receive a rate of $69.00 per day.~~

~~10/03~~ ~~9. Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of $268.00 per day~~

~~[MATERIAL REMOVED]~~

07/14 ~~07/08~~ 10. Reserved. ~~Hospitals qualifying under subsection (c)(1)(i) of this Section will receive a rate of $328.00 per day.~~

07/14 ~~07/05~~ 11. Reserved. ~~Hospitals qualifying under subsection C.1.a.iii.above, with respect to payments under this section:~~

~~a. Will have their rates multiplied by a factor of two.~~

~~b. The minimum may be adjusted by the Department to ensure compliance with aggregate upper payment limitation requirements at 42 *CFR* 447.272 and hospital specific payment limitations for DSH hospitals in Section 1923(g) of the *Social Security Act*. Rate adjustments will be conducted in accordance with Chapter XIII.I.3 of this Section.~~

~~c. A portion of the payments calculated under this Section may be classified as disproportionate share adjustment payments if there is allowable room under the State's federal DSH allotment, as determined in Section 1923(f) of the *Social Security Act*, and under the hospital specific OBRA test, which is conducted to ensure compliance with Section 1923(g) of the *Social Security Act*. The amount of the payment that will be classified, as DSH will be determined in the following manner:~~

~~i. One-half of this quarterly payment will be classified as DSH spending for federal reporting purposes.~~

~~ii. If the federal upper payment limit cap reduces spending by an amount that is greater than one-half the quarterly spending, the amount reclassified as DSH will be increased by the amount of the payment reduction that exceeded one-half of the original payment.~~

~~iii. The amount classified as DSH spending in subsection (1) or (2) will be constrained both by the available funding in the State's federal DSH allotment and the hospital specific OBRA test.~~

07/14 12. DHA Payments

a. Payments under this subsection D will be made at least quarterly~~, beginning with the quarter ending December 31, 1999.~~

b. Payment rates will be multiplied by the Total days.

~~c. Total Payment Adjustments~~

~~01/11~~ ~~For the CHAP rate period occurring January 1, 2011, to June 30, 2011, payments will equal the hospital's rate multiplied by Total days less the amount the hospital received under DHA for the quarters ending September 30, 2010 and December 31, 2010.~~

~~d. Payments under this subsection D that are made to disproportionate share hospitals in accordance with Chapter VI.C.5.7 will be considered to be disproportionate share payments, until September 30, 2002 except for payments made to hospitals defined in Chapter XIII.~~

07/14 E. Reserved.~~Rural Critical Hospital Adjustment Payments (RCHAP)~~

~~Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to rural hospitals as subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:~~

~~1. The product of $1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or~~

~~2. The product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.~~

07/14 F. Reserved. ~~Total CHAP Payment Adjustments – Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in sections A, B, C and E of this Chapter. The critical hospital adjustment payments shall be paid at least quarterly.~~

07/14 ~~01/11~~ G. Reserved. ~~Critical Hospital Adjustment Limitations.~~

~~1. Hospitals that qualify for trauma center adjustments under Section A. above shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in A.1.above, or a Level II trauma center as required for the adjustment described in A.3 or A.4.of this Chapter. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased. This limitation does not apply to hospitals qualifying under section A.2.~~

~~2. For a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 *ILCS* 5/5-30, no new payment or rate increase that would otherwise be effective for dates of service on or after January 1, 2011, shall take effect under Sections A, B, C, or E of this Chapter unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in Chapter XV.H.5. This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area.~~

H. Critical Hospital Adjustment Payment Definitions

1. "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates of service occurring in State fiscal year 2001and adjudicated through June 30, 2002

2. "CHAP base period" means State Fiscal Year 1994, for CHAP payments calculated for the July 1, 1995, CHAP rate period, State Fiscal Year 1995 for CHAP payments calculated for the July 1, 1996, CHAP rate period, etc.

3. "CHAP rate period" means, beginning July 1, 1995, the 12- month period beginning on July 1 of the year and ending June 30 of the following year.

4. "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1,1999, plus the Medicaid obstetrical inpatient utilization rate, as of July 1, 1999, both of which are defined in Chapter VI.C.8.

01/11 5. "Coordinated Care Participating Hospital" means a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 *ILCS* 5/5-30 that is one of the following:

   a. Has entered into a contract to provide hospital services to enrollees of the care coordination program.

   b. Has not been offered a contract by a care coordination plan that pays no less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that the Department pays directly.

c. Is not licensed to serve the population mandated to enroll in the care coordination program.

6. "Medicaid general care admission" means hospital inpatient admissions, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

07/14 7. Reserved. ~~"Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.~~

07/14 8. Reserved. ~~"Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (H)(5) above.~~

9. "Medicaid obstetrical care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with a Diagnosis Related Group (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.

07/14~~04/05~~ 10. Reserved. ~~"Medicaid trauma admission" means those claims billed as admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.31 , 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925 through 925.2, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the~~

~~claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18 excluding admissions for normal newborns.~~

07/14 11. Reserved. ~~"Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all level II urban trauma centers.~~

07/14 12. Reserved. ~~"RCHAP General Care Admission" means Medicaid General Care Admissions, as defined in subsection H.4 above, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.~~

07/14 13. Reserved. ~~"RCHAP Obstetrical Care Admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection H. 7 above, with a Diagnosis Related Group (DRG) of 370 through 375, occurring in the CHAP base period.~~

14. "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

15. "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

16. "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

K. Safety Net Hospital Adjustment Payments

07/14 ~~07/06~~ 1. Qualifying criteria: Safety net hospital adjustment payments shall be made to a qualifying hospital, as defined in this subsection (1). Unless the hospital does not provide Comprehensive emergency treatment services on or after July 1, 2006, but did provide such services on January 1, 2006. A hospital not otherwise excluded under subsection (2) below shall qualify for payment if it meets one of the following criteria:

a. It has, as provided in subsection K. ~~(5)(g)~~, a MIUR equal to or greater than the 40%

~~b. It has the highest number of obstetrical care days in the safety net hospital base year.~~

~~c. It is, as of October 1, 2001, a sole community hospital, as defined by the United States Department of Health and Human Services (42 CFR 412.92).~~

bd. It is, as of October 1, 2001, a rural hospital, as described in Chapter XVI, Section B.3, that meet the following criteria:

i. Has a MIUR greater than 33 percent.

ii. Is designated a perinatal level II center by the Illinois Department of Public Health

iii. Has fewer than 125 licensed beds.

~~e. It is a rural hospital, as described in Chapter XVI, Section B.3.~~

01/03 cf. The hospital meets all of the following criteria:

i. Has an MIUR greater than 30 percent.

ii. Had an occupancy rate greater than 80 percent in the safety net hospital base year.

iii. Provided greater than 15,000 days in the safety net hospital base year.

dg. The hospital meets all of the following criteria:

i. Does not already qualify under subsections 1(a) through (c) ~~(f)~~ of this section.

ii. Has a MIUR greater than 25 percent.

iii. Had an occupancy rate greater than 68 percent in the safety net hospital base year.

iv. Provided greater than 12,000 total days in the safety net hospital base year.

~~h. The hospital meets all of the following criteria in the safety net base year:~~

~~i. Is a rural hospital, as described in Chapter XVI, Section B.3 of this attachment.~~

~~ii. Has a MIUR greater than 18 percent.~~

~~iii. Has a combined MIUR greater than 45 percent.~~

~~iv. Has licensed beds less than or equal to 60.~~

~~v. Provided greater than 400 total days.~~

~~vi. Provided fewer than 125 obstetrical care days.~~

ei. The hospital meets all of the following criteria in the safety net base year:

i. Is a psychiatric hospital, as described in Chapter VII ~~Chapter II, Section C.1~~ of this aAttachment.

ii. Has licensed beds greater than 120.

iii. Has an average length of stay less than ten days.

07/06 fj. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsection 1(a) through 1(e)~~(i)~~ of this Section.

ii. Has an MIUR greater than 17 percent.

iii. Has licensed beds greater than 450.

iv. Has an average length of stay less than four days.

07/06 gk. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsection 1(a) through 1(f)~~(j)~~ of this Section.

ii. Has an MIUR greater than 21 percent.

iii. Has licensed beds greater than 350.

iv. Has an average length of stay less than 3.15 days.

~~07/06~~ ~~l. The hospital meets all of the following criteria in the safety net base year:~~

~~i. Does not already qualify under subsections 1(a) through 1(k) of this Section.~~

~~ii. Has an MIUR greater than 34 percent.~~

~~iii. Has licensed beds greater than 350.~~

~~iv. Is designated a perinatal level II center by the Illinois Department of Public Health.~~

~~07/06~~ ~~m. The hospital meets all of the following criteria in the safety net base year:~~

~~i. Does not already qualify under subsections 1(a) through 1(l) of this Section.~~

~~ii. Has an MIUR greater than 35 percent.~~

~~iii. Has an average length of stay less than four days.~~

07/06 hn. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsections 1(a) through 1(g)~~(m)~~ of this Section.

ii. Has a CMIUR greater than 25 percent.

iii. Has an MIUR greater than 12 percent.

iv. Is designated a perinatal level II center by the Illinois Department of Public Health.

v. Has licensed beds greater than 400.

vi. Has an average length of stay less than 3.5 days.

~~07/08~~ ~~o. (Reserved.)~~

~~02/08~~ ~~p. A hospital provider that would otherwise be excluded from payment by this subsection because it does not operate a comprehensive emergency room, if the hospital provider operates within one mile of an affiliate hospital provider that is owned and controlled by the same governing body that operate a comprehensive emergency room and the provider operates a standby emergency room, and functions as an overflow emergency room for its affiliate hospital providers.~~

~~02/08~~ ~~q. The hospital has an MIUR greater than 90% in the safety net hospital base year.~~

07/08 ihr. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsections 1.a. ~~(a)(1)~~ through 1.h. ~~(a)(17)~~ of this Section.

ii. Located outside Health Service Area (HSA~~HAS~~) 6.

iii. Has an MIUR greater than 16 percent.

iv. Has licensed beds greater than 475.

v. Has an average length of stay less than 5 days.

jis. The hospital meets all of the following criteria in the safety net base year:

i. Provided greater than 5,000 obstetrical care days.

ii. Has a Combined MIUR greater than 80 percent.

04/09 kjt. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsections 1(a) through 1(j)~~(i)~~ ~~(s)~~ of this Section.

ii. Has a CMIUR greater than 28 percent.

iii. Is designated a perinatal Level II center by the Illinois Department of Public Health.

iv. Has licensed beds greater than 320.

v. Had an occupancy rate greater than 37 percent in the safety net hospital base year.

vi. Has an average length of stay less than 3.1 days.

01/11 l.u. The hospital meets all of the following criteria in the safety net base year:

i. Does not already qualify under subsections 1(a) through 1(k)~~(t)~~ of this Section.

ii. Is a general acute care hospital.

iii. Is designated a perinatal Level II center by the Illinois Department of Public health.

iv. Provided greater than 1,000 rehabilitation days in the safety net hospital base year.

~~m.v. The hospital meets all of the following criteria in the safety net base year:~~

~~i. Qualifies as a children's hospital under Section 3.a.iii.~~

~~ii. Has an average length of stay less than 3.25 days.~~

~~iii. Provided more than 1,000 total days in the safety net hospital base year.~~

~~04/09~~ ~~2. The following five classes of hospitals are ineligible for safety net hospital adjustment payments associated with the qualifying criteria listed in 1(a) through 1(d), 1(f) through 1(h), 1(j) through 1(p), and 1(r) through 1(t) of this section:~~

~~a. Hospitals located outside of Illinois.~~

~~b. County-owned hospitals, as described in Section A.1.a.i. of Chapter XVI.~~

~~c. Hospitals organized under the *University of Illinois Hospital Act*, as described in Section A.1.a.ii. of Chapter XVI.~~

[MATERIAL REMOVED]

~~d. Psychiatric hospitals, as defined in Section C.1 of Chapter II.~~

~~e. Long term stay hospitals, as defined in Section C.4 of Chapter II.~~

~~3. Safety Net Hospital Adjustment Rates~~

~~a. For a hospital qualifying under subsection (1)(a) above, the rate is the sum of the amounts for each of the following criteria for which it qualifies:~~

~~i. A qualifying hospital -- $15.~~

~~ii. A rehabilitation hospital as defined in Section C.2 of Chapter II) -- $20.~~

~~iii. A children's hospital, as described under Section II.C.3 -- $20.~~

~~iv. A children's hospital that has a MIUR greater than or equal to 80 per centum that is:~~

~~07/06~~

~~A. Located within HSA 6 or HSA 7 -- $296.00.~~

~~B. Located outside HSA 6 or HSA 7 -- $35.~~

~~v. A children's hospital that has a MIUR less than 80 per centum, but greater than or equal to 60 per centum that is:~~

~~A. Located within HSA 6 or HSA 7 -- $35.~~

~~B. Located outside HSA 6 or HSA 7 -- $15.~~

~~vi. A children's hospital that has a MIUR less than 60 per centum, but greater than or equal to 45 per centum that is:~~

~~A. Located within HSA 6 or HSA 7 -- $12.~~

~~B. Located outside HSA 6 or HSA 7 -- $5.~~

~~07/08~~

~~vii. A children's hospital with more than 25 graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory" -- $160.25.~~

~~viii. A children's hospital that is a rural hospital -- $145.~~

~~ix. A qualifying hospital, that is neither a rehabilitation hospital nor a children's hospital, that is located in HSA 6 and that:~~

~~A. Provides obstetrical care – $10.~~

~~B. Has at least one graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – $5.~~

~~C. Has at least one obstetrical graduate medical education program, as listed in the "2000-2001 Graduate Medical Education Directory" – $5.~~

~~D. Provided more than 5,000 obstetrical days in the safety net hospital adjustment base period – $35.~~

~~E. Provided fewer than 4,000 obstetrical days in the safety net hospital adjustment base period and its average length of stay is:~~

~~1. Less than or equal to 4.50 days – $5.~~

~~2. Less than 4.00 days – $5.~~

~~3. Less than 3.75 days – $5.~~

~~F. Provides obstetrical care and has an MIUR greater than 65 percent – $11.00.~~

~~07/08~~ ~~G. Has greater than 700 licensed beds – $37.75~~

~~x. A qualifying hospital, that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6 that has a MIUR greater than 50 per centum, and that:~~

~~A. Provides obstetrical care – $280.00~~

~~07/08~~ ~~B. Does not provide obstetrical care – $120.00.~~

~~07/06~~ ~~C. Is a trauma center, recognized by the Illinois Department of Public Health (IDPH), as f July 1, 2005 – $173.50.~~

07/14 2. For a hospital qualifying under subsection 1.a.of this Section that is neither a rehabilitation hospital nor a children's hospital, that is located outside HSA 6, that has an MIUR greater than 50 per centrum, and that:

a. Provides obstetrical care – $210.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

b. Does not provide obstetrical care – $90.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

3. For a hospital qualifying under subsection 1.b. of this Section, the rate shall be $55.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

4. For a hospital qualifying under subsection 1.c of this Section, the rate is $3.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

5. For a hospital qualifying under subsection 1.d. of this Section, the rate is $140.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

6. For a hospital qualifying under subsection 1.e. of this Section, the rate is $119.50. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

7. For a hospital qualifying under subsection 1.f. of this Section, the rate is $25.00.

8~~7~~. For a hospital qualifying under subsection 1.g.~~1.f.~~ of this Section, the rate is $221.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

9~~8~~. For a hospital qualifying under 1.h. ~~1.g.~~ of this Section, the rate is $100.00. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

10.~~9~~. For a hospital qualifying under subsection 1.i. ~~1.h.~~ of this Section, the rate is $69.00. ~~The reimbursement rate is contingent on federal approval through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

11.~~10~~. For a hospital qualifying under subsection 1.j. ~~1.i.~~ of this Section, the rate is $56.00. ~~for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is $136.00. For dates of service on or after July 1, 2014 through December 31, 2014, the rate is $56.00. For dates of service on or after January 1, 2015, the rate is $0.00.~~

12.~~11~~. For a hospital qualifying under subsection 1.k. ~~1.j.~~ of this Section, the rate is $197.00. ~~$84.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

13. For a hospital qualifying under subsection 1.l. of this Section, the rate is $71.00.

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[MATERIAL REMOVED]

~~02/08~~

~~xi. A qualifying hospital that provided greater than 35,000 days in the safety net hospital base year – $43.25.~~

~~xii. A qualifying hospital with two or more graduate medical education programs, as listed in the "2000-2001 Graduate Medical Education Directory", with an average length of stay less than 4 days – $48.00.~~

~~07/08~~

~~b. For a hospital qualifying under Section (1)(b) of these rules, the rate shall be $123.00 for dates of service through March 2, 2013. The rate shall be increased by $41.00 to $164 for dates of service on or after March 3, 2013 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $123.00~~

~~c. For a hospital qualifying under Section (1)(c) of these rules, the rate is the sum of the amounts for each of the following for which it qualifies:~~

~~i. A qualifying hospital – $40.~~

~~ii. If it has an average length of stay less than 4.00 days and:~~

~~A. More than 150 licensed beds – $20.~~

~~B. Fewer than 150 licensed beds – $40.~~

~~iii. The eligible hospital with the lowest average length of stay – $15.~~

~~iv. It has a CMIUR greater than 65 per centum – $35.~~

~~v. It has fewer than 25 total admissions in the safety net hospital adjustment base period – $160.~~

~~07/08~~

~~d. For a hospital qualifying under subsection (1)(d) the rate shall be $110.~~

~~e. For a hospital qualifying under subsection (1)(e), the rate is the sum of the amounts for each of the following for which it qualifies divided by the hospital's total days:~~

~~i The hospital that has the highest number of obstetrical care admissions – $30,840.~~

~~ii. The greater of:~~

~~A. The product of $115 multiplied by the number of obstetrical care admissions.~~

~~B. The product of $11.50 multiplied by the number of general care admissions.~~

~~07/08~~

~~f. For a hospital qualifying under subsection (1)(f), the rate is $56.00.~~

~~07/12~~

~~g. For a hospital qualifying under subsection (1)(g) of this Section, the rate is $315.50 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $210.50.~~

~~01/11~~

~~h. For a hospital qualifying under subsection (1)(h) of this Section, the rate is $124.50.~~

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[MATERIAL REMOVED]

~~07/12~~ ~~i. For a hospital qualifying under subsection (1)(i) of this Section, the rate is $133.00. For dates of service on or after January 1, 2011 through December 31, 2014, this rate shall be increased by $72.00 to $205.00. For dates of service on or after January 1, 2015, the rate is $85.50.~~

~~01/11~~ ~~j. For a hospital qualifying under subsection (1)(j) of this Section, the rate is $13.75. For dates of service on or after January 1, 2011 through December 31, 2014, this rate shall be increased by $25.00 to $38.75.~~

~~12/09~~ ~~k. For a hospital qualifying under subsection (1)(k) of this Section, the rate is $421.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $39.50.~~

~~07/08~~ ~~l. For a hospital qualifying under subsection (1)(l) of this Section, the rate is $240.50.~~

~~04/09~~ ~~m. For a hospital qualifying under subsection (1)(m) of this Section, for dates of service on or after April 1, 2009, the rate is $815.00.~~

~~07/08~~ ~~n. For a hospital qualifying under subsection (1)(n) of this Section, the rate is $445.75.~~

~~07/08~~ ~~o. (Reserved.)~~

~~02/08~~ ~~p. For a hospital qualifying under subsection (1)(q) of this Section, the rate is $39.50.~~

~~07/08~~ ~~q. For a hospital qualifying under subsection (1)(r) of this Section, the rate is $69.00.~~

~~12/09~~ ~~r. For a hospital qualifying under subsection (1)(s) of this Section, the rate is $56.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $16.00.~~

~~01/11~~ ~~s. For a hospital qualifying under subsection (1)(t) of this Section, for dates of service on or after April 1, 2009, the rate is $229.00. For dates of service on or after January 1, 2011 through December 31, 2014, this rate shall be increased by $113.00 to $342.00. For dates of service on or after January 1, 2015, the rate is $145.00.~~

~~01/11~~ ~~t. For a hospital qualifying under subsection (1)(u) of this Section, the rate is $71.00 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

~~03/13~~ ~~u. For a hospital qualifying under subsection (1)(v) of this Section, the rate is $1986.00 for dates of service on or after March 3, 2013 through June 30, 2013. For dates of service on or after July 1, 2013, the rate is $0.00.~~

07/14 L. Tertiary Care Payments Prior to July 1, 2014.

Tertiary Care Adjustment Payments shall be made to all eligible hospitals, excluding county-owned hospitals as described in Chapter II.C.8 and hospitals organized under the University of Illinois Hospital Act, as described in Chapter II.C.8 for inpatient admissions occurring on or after July 1,2002, in accordance with this Section.

a. Definitions. The definitions of terms used with reference to calculation of payments under this Section are as follows:

1. "Base Period Claims" means claims for inpatient hospital services with dates of service occurring in the Tertiary Adjustment Base Period that were subsequently adjudicated by the Department though December 31, 1999. For a general care hospital that includes a facility devoted exclusively to caring for children and that was separately licensed as a hospital by a municipality before September 30, 1998, Base Period Claims for services that may, in Chapter II.C.3.a, be billed by a children's hospital shall be attributed exclusively to the children's facility. Base Period Claims shall exclude the following types:

i. Claims for which Medicare was liable in part or in full (cross-over" claims)

ii. Claims for transplantation services that were paid by the Department via form C-13, Invoice Voucher; and

iii. Claims for services billed under categories of service 037 and 038 (exceptional care services)

04/09 b. "Case Mix Index" or "CMI", for all hospitals qualifying under this subpart K, means the sum of all Diagnosis Related Grouping (DRG)(see Chapter I.F.) Weighting factors for Base Period Claims divided by the total number of claims included in the sum, but excluding claims.

8. Tertiary Care Adjustment

   i. The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (2) through (7) of this Section multiplied by 0.455.

   ii A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.

4/09 iii. For hospitals qualifying for payments under this Section for the adjustment period beginning April 1, 2009, total payments will equal the sum of the amounts calculated under the methodologies described in this Section less the Tertiary Care Adjustment amounts received from July 1, 2008 through March 31, 2009.

07/14 M. Reserved. ~~Psychiatric Adjustment Payments~~

~~1. Qualifying criteria: Psychiatric adjustment payments shall be made to a qualifying hospital, as defined in this subsection (1). A hospital not otherwise excluded under subsection (2) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:~~

~~a. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in (5)(e) greater than 60 percent.~~

~~b. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 20 percent; has greater than 325 total licensed beds as described in (5)(b); and has a psychiatric occupancy rate described in (5)(d), greater than 50 percent.~~

~~c. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 15 percent; has greater than 500 total licensed beds as described in (5)(b); has a psychiatric occupancy rate as described in (5)(d) greater than 35 percent; and has total licensed psychiatric beds described in (5)(c) greater than 50.~~

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[MATERIAL REMOVED]

~~d. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a. enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 19 percent; has less than 275 total licensed beds as described in (5)(b); has less than 1,000 total psychiatric care days as described in (5)(h); has 40 or less total licensed psychiatric beds as described in subsection (5)(e) of this section; has greater than 6,000 total days as described in subsection (5)(i) of this section.~~

~~07/05~~ ~~e. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter II, D.1, enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric part unit average default rate; is located outside of HSA 6; has 50 or more total licensed psychiatric beds as described in subsection (5)(e) of this section; has a psychiatric occupancy rate described in (5)(d), greater than 60 percent.~~

~~2. The following five classes of hospitals are ineligible for Psychiatric adjustment payments associated with the qualifying criteria listed in subsections (1)(a) through (1)(d) of this Section:~~

~~a. Hospitals located outside of Illinois.~~

~~b. Hospitals located inside HSA 6.~~

~~c. Psychiatric hospitals, as described in Chapter II, C.1.~~

~~d. Long term stay hospitals, as described in Chapter IIC 4.~~

~~e. A children's hospital, as described in Chapter II.C.3.~~

~~3. Psychiatric Adjustment Payment Rates~~

~~a. For a hospital qualifying under subsection (1)(a) the rate is $63.00.~~

~~b. For a hospital qualifying under subsection (1)(b) that:~~

~~i. Has less than 10,000 total days the rate is $78.00.~~

~~ii. Has equal to or greater than 10,000 total days the rate is $125.00.~~

~~c. For a hospital qualifying under subsection (1)(c) the rate is $21.00.~~

~~d. For a hospital qualifying under subsection (1)(d) the rate is $38.00.~~

~~07/05~~ ~~e. For a hospital qualifying under subsection (1)(e) the rate is $140.00.~~

~~4. Payment to a Qualifying Hospital~~

~~a. The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (3) multiplied by total days as described in (5)(i).~~

~~b. The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment Period in installments on, at least, a quarterly basis.~~

~~5. Definitions~~

~~a. "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.~~

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[MATERIAL REMOVED]

~~b. "Total Licensed Beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."~~

~~c. "Licensed Psychiatric Beds" means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."~~

~~d. "Psychiatric Occupancy Rate" means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."~~

~~e. "MIUR" for a given hospital, has the meaning as defined in Chapter VI, Section C.8.e, and shall be determined in accordance with Chapter VI, Sections C.3 and C.6. For purposes of this State Plan, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.~~

~~f. Psychiatric Adjustment Payment base year" means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.~~

~~g. Psychiatric Adjustment Payment Period" means, beginning October 1, 2002, the 9 month period beginning October 1 ending June 30 of the following year, and beginning July 1, 2003 the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~

~~h. "Total Psychiatric care days" means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Chapter XV, Section H.4., provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the psychiatric adjustment payment base year that were adjudicated by the Department through June 30, 2001.~~

~~[MATERIAL REMOVED]~~

~~i. "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the psychiatric adjustment payment base year base year that were adjudicated by the Department through June 30, 2001.~~

~~j. "Psychiatric Care Average Length of Stay" means the quotient, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which is the number of admissions in the Psychiatric Adjustment Payment base year.~~

07/14 N. Reserved. ~~Rural Adjustment Payments~~

~~1. Qualifying criteria: Rural Adjustment Payments shall be made to all qualifying general acute care hospitals which are designated as a Critical Access Hospital or a Necessary Provider, as defined by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F, as of the first day of July in the Rural Adjustment Payment rate period.~~

[MATERIAL REMOVED]

~~2. Rural Adjustment Rates:~~

~~a. Inpatient component: For a hospital qualifying under subsection (1) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows;~~

~~i. Total inpatient payments as described in subsection (4)(b) of this section, shall be divided by the total inpatient days, as described in subsection (4)(d) of this section, to derive an inpatient payment per day.~~

~~ii. Total inpatient charges, associated with inpatient days as described in subsection (4)(d) of this section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (4)(a) of this section, to derive total inpatient cost.~~

~~iii. Total inpatient coverage cost as defined in subsection (2)(a)(ii) of this section, are divided by the total inpatient days, as described in subsection (4)(d) of this section, to derive an inpatient cost per day.~~

~~iv. Inpatient payment per day, as defined in subsection (2)(a)(i) of this section, shall be subtracted from the inpatient cost per day, as described in subsection (2)(a)(iii) of this section, to derive an inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.~~

~~v. Inpatient cost coverage deficit per day, as described in subsection (2)(a)(iv) of this section, shall be multiplied by the total inpatient days, as described in subsection (4)(d) of this section, to derive a total hospital specific inpatient cost coverage deficit.~~

~~vi. The inpatient cost deficits, as described in subsection (2)(a)(v) of this section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.~~

[MATERIAL REMOVED]

~~b. Payment Methodology: A $7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as follows:~~

~~i. The total inpatient cost coverage deficit as described in subsection (2)(a)(vi) of this section, is added to the total outpatient cost coverage deficit as described in subsection (2)(b)(vi) of this section, to derive a total Rural Adjustment Payment base year deficit.~~

~~ii. The inpatient pool allocation percentage shall be the quotient, the numerator of which is the total inpatient cost deficit, as described in subsection (2)(a)(vi) of this section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in (2)(c)(i) of this section.~~

~~iii. An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (2)(c)(ii) of this section, multiplied by the $7 million pool, as described in (2)(c) of this section.~~

~~iv. An inpatient residual cost coverage factor shall be the quotient, the numerator of which shall be the inpatient pool allocation, as described in subsection (2)(c)(iv) of this section, the denominator of which shall be the total inpatient cost deficit as described in subsection (2)(a)(vi) of this section.~~

~~v. Hospital specific inpatient cost coverage adjustment amount, shall be the product of the inpatient residual cost coverage factor, as described in subsection (2)(c)(vi) of this section, multiplied by the hospital specific inpatient cost coverage deficit, as described in subsection (2)(a)(v) of this section.~~

~~3. Payment to a Qualifying Hospital~~

~~a. The total annual adjustment amount to a qualified hospital shall be the inpatient cost coverage adjustment amount, as described in subsection (2)(b)(v) of this section.~~

~~b. The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (4)(e) of this section on at least a quarterly basis.~~

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPTIAL REIMBURSEMENT; MEDICAL ASSISTANCE-GRANT (MAG) and MEDICAL ASSISTANCE-NO GRANT (MANG)

[MATERIAL REMOVED]

~~4. Definitions.~~

~~a. "Hospital cost to charge ratio", means the quotient, the numerator of which is the cost as reported on Form HCFA 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form HCFA 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, for SFY 2004 the hospital's fiscal year 2000 cot report shall be utilized. The base year for any SFY shall be determined in this manner.~~

~~b. "Inpatient Payments", shall mean all payments associated with total days provided, as described in subsection (4) (c) of this section, and all quarterly adjustment payments paid, as described in the State Plan.~~

~~c. "Total Days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~

~~d. Rural Adjustment Payment base year" means for the Rural Adjustment Payment rate period beginning October 1, 2002, State fiscal year 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, State fiscal year 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.~~

~~e. "Rural Adjustment Payment Rate Period" means, beginning October 1, 2002, the 9 month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003 the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~

O. Transitional Supplemental

To provide stability to the hospital industry in the midst of replacing a twenty year old reimbursement system that relied heavily on non-claims based static payments, in favor of an updated APR-DRG grouper for inpatient services and an entirely new outpatient reimbursement methodology in the EAPG system, the Department shall create transitional supplemental payments to hospitals. These payments are essential to maintaining access to care for an expanding population of Illinois Medical Assistance recipients for a limited time period to allow the hospital providers time to adjust to the new reimbursement policies, rates, and methodologies.

1. Transitional Supplemental Payments shall be made to ~~DRG PPS~~ providers with a simulated payment loss under the new inpatient and outpatient systems combined.

   a. The following providers will not qualify for Transitional Supplemental Payments:

      i. ~~Freestanding psychiatric, rehabilitation, LTAC providers, u~~University-owned large public hospitals, county-owned large public hospitals, children's specialty hospitals and non-cost reporting hospitals.

      ii. ~~DRG PPS p~~Providers with a simulated payment gain under the new inpatient and outpatient systems combined.

   b. Simulated payment loss or gain under the new inpatient and outpatient systems combined shall be based on:

      i. SFY 2013 legacy system reported claim payments: Reported payments in Illinois Medicaid FFS inpatient and outpatient paid claims data, including Medicare-Medicaid dual eligible claims and non-Medicare eligible claims, for claims with submittal dates during SFY 2013 and admission dates on or after July 1, 2011, excluding DSH payments, outpatient therapy claims, and claims with invalid/ungroupable inpatient DRGs or outpatient EAPGs.

      ii. SFY 2013 new system simulated claim payments: Simulated payments under the new inpatient and outpatient systems using SFY 2013 claims data described in subsection (a)(2)(A) of this Section, including MPA/MHVA payments and excluding DSH payments and inpatient GME payment increases.

      iii. SFY 2011 legacy system supplemental payments, excluding payments that will continue in current form in SFY 2015.

iv. All legacy and new system payment amounts used to determine Transitional Supplemental Payments will be adjusted for SMART Act reductions.

v. Estimated payment gain or loss under the combined new inpatient and outpatient systems shall be determined as follows: (Simulated new system SFY 2013 claim payments) – [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].

~~vi. Estimated payment gain or loss percentage under the combined new inpatient and outpatient systems shall be determined as follows: (Estimated payment gain or loss) / [(Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments)].~~

2. Transitional Supplemental Payments for qualifying providers shall be equal to the estimated payment loss under the combined new inpatient and outpatient systems, as defined in subsection O.1.b.v. of this Section. ~~the sum of the following components:~~

~~a. Floor Component: Based on the supplemental payments needed to result in a provider's estimated payment loss of negative three percent, rounded to the nearest thousand dollars, using the following formula:~~

~~i. [((Reported legacy system SFY 2013 claims payments) + (SFY 2011 legacy system supplemental payments))* 0.97] – (Simulated new system SFY 2013 claim payments).~~

~~ii. A provider with an estimated payment loss percentage less than three percent will have a Floor Component equal to $0.00.~~

~~b. Balance Component: Based on a percent of the provider's remaining estimated loss after including the Floor Component, rounded to nearest thousand dollars, using the following formula:~~

~~i. [((Simulated new system SFY 2013 claims payments) + (Floor Component)) – ((Reported legacy system SFY 2013 claim payments) + (SFY 2011 legacy system supplemental payments))] * (Balance Adjustment Percentage) * -1.~~

~~ii. Balance Adjustment Percentage based on provider type as follows:~~

~~A. Safety Net hospitals: 70 percent~~

~~B. Critical Access hospitals: 70 percent~~

~~C. Hospital with both Perinatal level III and Trauma level I status: 70 percent~~

~~D. All other qualifying DRG PPS hospitals with an estimated payment loss: 55 percent.~~

3. Timing.

a. The Department shall make Transitional Supplemental Payments for the first four ~~two~~ years of the new inpatient and outpatient payments systems effective during SFY 2015 through 2018~~and 2016~~.

~~b. Commencing January 2017October 2015, the Department shall convene a Technical Advisory Group to determine the need to continue any new supplemental payments to maintain access to care, to be effective July 1, 2018 2016. Any new supplemental payments may be based on one or more of the following considerations critical to maintaining access to care for those eligible for Medicaid services:~~

~~i. Provider-specific payment increases received from the Medicaid expansion population.~~

~~ii. Provider-specific Medicaid volume (both total volume and Medicaid utilization rate).~~

~~iii. Provider-specific new system payments compared to UPL cost.~~

~~iv. Provider-specific new system payments compared to estimated payments under Medicare, using an aggregate Medicare payment-to-charge ratio.~~

~~v. Provider-specific payments under the hospital assessment.~~

~~vi. Available inpatient and outpatient UPL gap for each provider class.~~

~~vii. The financial implications of the loss of Transitional Supplemental Payments in excess of $10,000,000 and have an MIUR at least of one and on-half standard deviations above the mean.~~

~~viii. An analysis of new hospital revenues and losses from all sources.~~

~~c. Effective July 1, 20182016, the Department shall direct unused funds from legacy Transitional Supplemental Payments to increase either inpatient DRG PPS base rates or EAPG PPS conversion factors, adjust current policy adjustors defined in Chapter IV subsections 148.140(f) and 149.100(f) if needed, and/or create new policy adjustors, which may include but not be limited to, Perinatal level II or II+ facilities and expensive drugs and devices if needed, based on analysis and recommendations from the Technical Advisory Group defined in subsection (c)(2) of this Section.~~

P. Hospital Payment Documentation and Coding Improvement Adjustment

1. Inpatient Hospital Payment Documentation and Coding Improvement (DCI) Adjustment

   a. The Department shall monitor changes in inpatient hospital statewide average case mix for services provided in the first two years following implementation of the APR-DRG payment methodology, and retrospectively adjust DRG base rates to offset the impact of paid case mix differential attributable to DCI.

   b. Measuring case mix differential attributable to DCI:

      i. Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the Medicare-Severity DRG (MS-DRG) grouper and relative weights for:

         A. Claims with dates of service in State fiscal year 2011.

         B. Claims with dates of service in State fiscal years 2015 and 2016, consistent with subsection 1.c. ~~(a)(3)~~ of this Section.

      ii. Calculate the percentage point change, rounded to the nearest hundredth, in statewide average case mix using Version 30 of the APR-DRG weighting factors for the same periods specified in subsection 1.b.i.~~(a)(1)(A)~~ of this Section.

      iii. The case mix differential that is attributable to DCI is equal to the difference between the change in the aggregate APR-DRG case mix and the change in the aggregate MS-DRG case mix, for the claims described in subsection 1.b.i.~~(a)(1)(A)~~ of this Section.

      iv. Claims for services provided in State fiscal years 2015 and 2016 that were not paid by the Department using the APR-DRG payment methodology shall be excluded when measuring the case mix differential.

c. Timing:

i. Calculate case mix differential attributable to DCI for claims with Dates of Service (DOS) in SFY 2015 (first year of implementation) as of:

A. July 1, 2015, using all claims adjudicated as of that date with DOS in SFY 2015.

B. January 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.

C. April 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2015.

ii. Calculate case mix differential attributable to DCI for claims with DOS in SFY 2016 (second year of implementation) as of:

A. July 1, 2016, using all claims adjudicated as of that date with DOS in SFY 2016.

B. January 1, 2017 using all claims adjudicated as of that date with DOS in SFY 2016.

C. April 1, 2017, using all claims adjudicated as of that date with DOS in SFY 2016.

d. Adjusting for case mix changes attributable to DCI:

i. For any measurement period described above, if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the DRG base rates by the measured case mix differential less two percentage points.

ii. For any measurement period described above, if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the DRG base rates by the measured case mix differential plus two percentage points.

iii. The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the DRG base rates.

~~d. Adjusting for case mix changes attributable to DCI:~~

~~i. For any measurement period described above, if the case mix differential attributable to DCI is greater than two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential less two percentage points.~~

~~ii. For any measurement period described above, if the case mix differential attributable to DCI is less than minus two percentage points, the Department will adjust the EAPG conversion factor by the measured case mix differential plus two percentage points.~~

~~iii. The Department will retroactively adjust the payments for all claims adjudicated as of the measurement period for the changes in the EAPG conversion factors.~~

~~iv. The EAPG conversion factor, after adjustments pursuant to subsections (b)(4)(A) and (B) of this Section, shall be in effect until the next measurement period.~~

Q. Medicaid Facilitation and Utilization Payments shall be made on a monthly basis as follows:

1. Qualifying Hospitals. Hospitals may qualify for the Medicaid Facilitation and Utilization Payments if they meet any of the following criteria:

   a. The hospital must be an Illinois general acute care hospital that had an increase over 35% of the total Medicaid days, excluding Medicare crossover days, from State Fiscal Year 2009 to State Fiscal Year 2013 as recorded in the Department's paid claims data, had more than 50 routine beds as included in the 2012 cost report filed with the Department, and for State Fiscal Year 2013, the average length of stay was less than 4.5 days.

   b. The hospital must be an Illinois general acute care hospital that had a Medicaid Inpatient Utilization Rate (MIUR), as defined in Chapter VI section C.8.c of this attachemnt, between 50 and 80 percent, is designated a Perinatal Level II facility, and had less than 110 routine beds as included in the 2012 Cost Report on file with the Department, and for State Fiscal Year 2013, provided greater than 6,000 Medicaid days, excluding Medicare crossover days, as recorded in the Department's paid claims database.

   c. The hospital must be an Illinois children's hospital, as defined in Chapter VII of this attachment, had greater than 10 routine beds as included in the 2012 cost report on file with the Department, and for State Fiscal Year 2013, the average length of stay was less than 4.5 days.

2. Rates

a. Hospitals qualifying under subsection 1.a. of this Section will receive the following:

i. If the hospital provided more than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is $947.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is $0.00.

ii. If the hospital provided less than 4,000 covered Medicaid days, excluding Medicare crossover days in State fiscal year 2013, as recorded in the Department's paid claims database, the rate is $76.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is $0.00.

b. Hospitals qualifying under subsection 1.b. of Section will receive the following:

i. If the hospital had greater than 100 routine beds as included in the 2012 Cost Report on file with the Department, the rate is $205.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is $0.00.

ii. If the hospital had less than 100 routine beds as included in the 2012 Cost Report on file with the Department, the rate is $59.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is $0.00.

c. Hospitals qualifying under subsection 1.c. of this Section will receive a rate of $390.00 for dates of service on or after July 1, 2014 through June 30, 2018. For dates of service on or after July 1, 2018, the rate is $0.00.

3. Payment for a qualifying hospital shall be the product of the rate as defined in subsection 2. of this Section, multiplied by their SFY 2013 covered days less Medicare crossover days as recorded in the Department's paid claims data (adjudicated through February 21, 2014).

XVII. Reserved. ~~Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act~~

~~05/95~~ ~~A. The Department shall make supplemental disproportionate share (DSH) payments in accordance with this Chapter to hospitals that meet all of the following requirements:~~

~~05/95~~ ~~1. Qualify for DSH payment adjustments in accordance with Chapter VI, Section C.1.~~

~~05/95~~ ~~2. Are organized under the Town Hospital Act [60 *ILCS* 55].~~

~~05/95~~ ~~3. Have entered into an agreement, approved by the Director.~~

~~05/95~~ ~~B. Review Procedure~~

~~05/95~~ ~~The review procedure shall be in accordance with Chapter IX.~~

~~05/95~~ ~~C. Applicable Adjustments for Disproportionate Share Hospitals (DSH)~~

~~05/95~~ ~~1. The criteria and methodology for making applicable adjustments to government owned DSH hospitals as described in Section A of this Chapter shall be in accordance with Chapter VI.~~

~~05/95~~ ~~2. Effective with dates of service on or after May 13, 1995, in addition to the DSH payment adjustments described in Chapter VI, hospitals reimbursed under this Chapter shall be eligible for supplemental DSH payments. Effective with admissions on or after May 13, 1995, supplemental DSH payments for hospitals reimbursed under this Chapter shall be calculated by multiplying the sum of the hospital's alternate cost per diem rate in effect on May 13, 1995, as described in Chapter VIII, Sections A.2 and B, and the calculated disproportionate share per diem payment adjustment in effect on May 13, 1995, as described in Chapter VI, by the hospital's percentage of charges which are not reimbursed by a third party payor for the period of August 1, 1991 through July 31, 1992. The resulting product shall be multiplied by 6.25 and this amount shall be the supplemental DSH payment which shall be paid on a per diem basis and shall be applied to each covered day of care provided. The supplemental DSH~~

[MATERIAL REMOVED]

~~payments can not exceed the amount the hospital certifies as costs eligible for Federal Financial Participation under Title XIX of the *Social Security Act*.~~

~~05/95~~ ~~3. DSH adjustments made under this subsection are subject to the DSH adjustment limitations described in Chapter VI.C.7.f.~~

~~05/95~~ ~~D. Rate Period~~

~~05/95~~ ~~The rate period for hospitals reimbursed under this Chapter shall be the 12-month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of May 13, 1995 through September 30, 1995.~~

XVIII. ~~REPEALED~~ Medical Research and Enhancement Payments

A. Definitions.

1. "Physician Development Incentive payment funds" will be $3,000,000 annually ~~beginning July 1, 2014. An additional $13,000,000 will be added for the period beginning January 1, 2015 through June 30, 2015. Beginning July 1, 2015, the incentive funds will be $29,000,000 annually thereafter~~. Physician development incentive payments are described in Section B.~~H~~ of this Chapter.

2. "Primary care GME programs" means either Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) Post Graduate accredited residency programs in Family Medicine, Internal Medicine, Pediatrics and Internal Medicine-Pediatrics. Programs that are dual accredited by the ACGME and AOA are only eligible for a single yearly payment.

3. "Significant medically underserved populations" means more than 50 percent of the individuals served by a qualifying residency practice clinic enrolled Medicaid or are uninsured. The denominator used in this calculation shall include all resident continuity clinics in a GME program practice. When more than one site is used for resident continuity of care practice, the designated practice site or sites used to calculate percent medically underserved must contain greater than 75% of all patients seen by residents in continuity practice.

4. Tier I. A private academic medical center must:

   a. be a hospital located in Illinois which is:

      i. under common ownership with the college of medicine of a non-public college or university; or

      ii. a freestanding hospital in which the majority of the clinical chiefs of service or clinical department chairs are department chairmen in an affiliated non-public Illinois medical school; or

      iii. a children's hospital which is separately incorporated and non-integrated into the academic medical center hospital but is the pediatric partner for an academic medical center hospital and which serves as the primary teaching hospital for pediatrics for its affiliated Illinois medical school. A hospital identified herein is deemed to meet the additional Tier I criteria if its partner academic medical center hospital meets the Tier I criteria.

   b. serve as the training site for at least 30 graduate medical education programs accredited by Accreditation Council for Graduate Medical Education;

   c. facilitate the training on the campus or on affiliated off-campus sites no less than 500 medical students, interns, residents, and fellows during the calendar year preceding the beginning of the State fiscal year;

~~MATERIALS REMOVED~~

d. perform either itself or through its affiliated university, at least $12,000,000 in medical research funded through grants or contracts from the National Institutes of Health or, with respect to hospitals described in subsection (h)(1)(A)(ii), have as its affiliated non-public Illinois medical school, a medical school that performs either itself, or through its affiliated University, medical research funded using at least $12,000,000 in grants or contracts from the National Institutes of Health; and

e. expend directly or indirectly through an affiliated non-public medical school or as part of a hospital system as defined as a hospital and one or more other hospitals or hospital affiliates related by common control or ownership, no less than $5,000,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.

5. Tier II. A public academic medical center must:

a.. be a hospital located in Illinois that is a primary teaching hospital affiliated with:

i. University of Illinois School of Medicine at Chicago; or

ii. University of Illinois School of Medicine at Peoria; or

iii. University of Illinois School of Medicine at Rockford; or

iv. University of Illinois School of Medicine at Urbana; or

v. Southern Illinois University School of Medicine in Springfield; and

b. contribute no less than $2,500,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.

6. Tier III. A major teaching hospital must:

a. be an Illinois hospital with 100 or more interns and residents or with a ratio of interns and residents to beds greater than or equal to 0.25; and

b. support at least one graduate medical education program accredited by Accreditation Council for Graduate Medical Education.

i. "GME" means graduate medication education.

ii. "GME rate year" means the twelve-month period beginning on July 1 of each year; with the first GME rate year to begin on July 1, 2014.

~~MATERIALS REMOVED~~

B. Physician Development Incentive Payments as defined in A.

1. A Medicaid Graduate Medical Education (GME) fund in Illinois will support and align with the State's current and projected physician workforce needs and goals including:

   a. increasing the number of primary care providers in Illinois,

   b. increasing the number of primary care providers working in medically underserved areas, and

   c. increasing the number of providers who are trained to practice in a patient-centered medical home setting within an integrated delivery system.

2. The performance criteria for incentive payments will be as follows:

   a. 50 percent of funds are set aside for GME program resident continuity clinics meeting standards for at least one of the following:

      i. Level II or III Patient Centered Medical Homes by the National Center for Quality Assurance.

      ii. Primary Care Medical Home Certification by the Joint Commission.

      iii. Medical Home Accreditation by the Accreditation Association for Ambulatory Health Care.

      Each program within a hospital meeting one of these certification or accreditation standards will receive an equal share of these funds.

   b. 25 percent of funds will be set aside for resident practice clinics with significant medically underserved populations.

      Each program within a hospital meeting these standards will receive an equal share of these funds.

   c. 25 percent of funds set aside for written curricula in population medicine based on practice in continuity of care settings. The curriculum must contain competencies in population medicine. Population medicine curriculum competencies should include: preventive medicines; information technology for managing continuity of care practice panels; managing transitions of care; participating in team-based care and supporting patient-centered decision making. Programs must document that all residents received at least 20 hours a year in instruction in these areas.

      Each program within a hospital meeting these standards will receive an equal share of these funds.

~~MATERIALS REMOVED~~

3. Residency programs and the sponsoring medical centers will collect all information to be submitted for this program to HFS by June 1, each GME rate year. This includes, proof of certification requirements required in subsection 2.a. ~~(b)(1)~~, internal GME residency program data, and queries of GME program recent graduates.

4. The submitted data from eligible GME programs will be reviewed for meeting program performance standards. The Department may require for corroborating information and audit, any submission.

5. All GME residency programs meeting performance standards and qualifying to receive program funding will be announced annually. Subsequent to its determination of qualifying programs, the Department will disburse program funds to the hospitals that sponsor qualifying GME residence programs.

6. The Department shall recover – through repayment by or recoupment against other funds payable to, the hospital – program funds that have been found to have been disbursed in error.

07/14 XX. Pediatric Inpatient Adjustment Payments Prior to July 1, 2014

Pediatric Inpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section II.C.8, and hospitals organized under the University of Illinois Hospital Act, as described in Chapter II.C.8, for inpatient services occurring on or after July 1, 1998, in accordance with this Section.

A. To qualify for payments under this Chapter, a hospital must be a children's hospital, as defined in Chapter II.C.3, that was licensed by a municipality on or before December 31, 1997. Hospitals qualifying under this Section shall receive an adjustment for inpatient services equal to the product of the hospital's psychiatric and physical rehabilitation days, provided to children under 18 years of age during the adjustment base year, multiplied by $816 per day. Payments under this subsection will be based on the following methodology:

   1. The calculation under subsection A. of this Chapter may not exceed 850 days.

   2. For the purposes of calculating payments under this Chapter, the adjustment base year shall be psychiatric and physical rehabilitation days of care provided by the portion of the hospital that the Department does not recognize as a children's hospital. Such days include those provided in State fiscal year 1997 and adjudicated by the Department through March 31, 1998.

B. In addition to the payments described under subsection A. above, any children's hospital, as defined in II.C.3 will receive an additional adjustment equal to the product of the hospital's paid days, excluding Medicare crossover claims, multiplied by $113 per day. Such days include those provided in State fiscal year 1999 and adjudicated by the Department through May 31, 1999.

C. For rate years occurring after State fiscal year 2000, total payments made under subsection A and B. above shall be paid at least quarterly.

XXI. General provisions.

07/08 Unless otherwise indicated, the following apply to Chapters XXIII through XXX.

A. Definitions.

07/14 "ANNUAL PAYMENT" described in Chapter XX means amount calculated in SFY 2005.

"BASE INPATIENT PAYMENTS" means, for a given hospital, the sum of payments made using the rates defined in subsection B.2.c of Chapter IV and subchapters B, C, and D of Chapter VIII for services provided during State fiscal year 2005 and adjudicated by the Department through March 23, 2007.

"CAPITAL COST PER DIEM" means, for a given hospital, the quotient of (i) the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by (ii) the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies (DRI) hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department shall use the data reported on the hospital's 2005 Medicaid cost report.

"CASE MIX INDEX" means, for a given hospital, the quotient resulting from dividing (i) the sum of the all diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 *Ill. Adm. Code* 148.82, by (ii) the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions ~~reimbursed under 89 *Ill. Adm. Code* 148.82~~.

"CHILDREN'S HOSPITAL" means a hospital as described in Chapter VII ~~Section C.3 of Chapter II~~.

"ELIGIBILITY GROWTH FACTOR" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

"FREESTANDING CHILDREN'S HOSPITAL" means an Illinois CHILDREN'S HOSPITAL that is licensed by the Department of Public Health as a pediatric hospital.

07/08 XXX. Payment to government-owned or -operated hospitals.

A. Definitions.

10/10 "BASE PERIOD" means the hospital fiscal year ending during the calendar year that is three years prior to the calendar year during which the payment period begins.

"PAYMENT PERIOD" means the State fiscal year.

B. Notwithstanding any other provision of this Attachment, reimbursement to LARGE PUBLIC HOSPITALS shall be at allowable cost, as determined in section D of this chapter.

C. Hospitals that are located in Illinois and are owned or operated by a county or a unit of local government that are not LARGE PUBLIC HOSPITALS shall be reimbursed at the greater of:

1. Under the payment methodologies otherwise provided for in this Attachment.
2. At allowable cost, as determined in section D of this chapter.

D. Hospitals reimbursed under this chapter shall be reimbursed at allowable cost on a per diem basis. The per diem rate shall be calculated as follows:

1. BASE PERIOD costs are determined as the product resulting from multiplying (i) the routine and ancillary charges on claims that were submitted by the hospital for Medicaid covered services provided during the BASE PERIOD and paid by the department by (ii) their respective cost-to-charge ratios from the BASE PERIOD cost report.

2. BASE PERIOD costs are then adjusted by subtracting the sum of all periodic (weekly, monthly, quarterly, *etc.*) lump sum payments specified in this Attachment, with the exception of any payment that is classified as a disproportionate share hospital adjustment payment, that are expected to be made during the PAYMENT PERIOD.

3. For hospitals reimbursed under subsection C.2, the BASE PERIOD costs are additionally reduced by an amount necessary to ensure:

   a. That reimbursement to non-State government-owned or operated hospitals, as a class, is compliant with the upper payment limit requirement in 42 *CFR* 447.272.
   b. That the proportion of allowable costs that are reimbursed is the same for each hospital.

03/14 4. The BASE PERIOD costs are further adjusted to reflect the change, from the midpoint of the BASE PERIOD to the midpoint of the PAYMENT PERIOD, in the CMS hospital input price index. ~~For LARGE PUBLIC HOSPITALS, as defined in Chapter XVI, Section A.1.a.i., the adjustment factor will be the average annual growth in each hospital's cost per diem. The average annual growth shall be calculated as follows:~~

~~a. Inpatient average cost per diems are calculated using Medicaid claims data from two sets of fiscal years that are two years apart. Costs are determined in accordance with the methodology in this Section.~~

~~b. An average annual increase is calculated based on the percentage change in the average inpatient cost per diems over the two year time period.~~

~~c. The fiscal years used to determine the average annual growth will be updated annually. For example, the fiscal year 2011 rate trend factors are based upon cost per diem information from fiscal years 2006 and 2008; while fiscal year 2012 factors will be based upon cost per diem information from fiscal years 2007 and 2009.~~

5. The per diem rate is the quotient resulting from dividing the adjusted BASE PERIOD costs by the number of patient days on claims that were submitted by the hospital for Medicaid covered services provided during the BASE PERIOD and paid by the department.

~~[MATERIAL REMOVED]~~

XXXI. Reserved. ~~Catastrophic Relief Payments~~

04/09 ~~A. Qualifying Criteria. Catastrophic Relief Payments, as described in this section, shall be made to Illinois hospitals, except publicly owned or operated hospitals or a hospital identified under Section C.3.b of Chapter II, that have an MIUR greater than the current statewide mean, are not a publicly owned hospital, and are not part of a multiple hospital network, unless the hospital has an MIUR greater than the current statewide mean plus two standard deviations. Payments to qualifying hospitals will be based on criteria described in this Section.~~

~~B. Payments.~~

~~1. An Illinois hospital qualifying under subsection a. of this Section that is a general acute care hospital with greater than 3,000 Medicaid admissions, and a case mix greater than 70%, will receive the greater of:~~

~~a. Medicaid admissions multiplied by $2,250; or~~

~~b. $8,000,000.~~

~~2. Payments under this Section are effective for State fiscal year 2009. Payments are not effective for dates of service on or after July 1, 2009.~~

~~C. Definitions~~

~~1. "MIUR" means Medicaid inpatient utilization rate as defined in Section C.8.e of Chapter VI. For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.~~

~~2. "General acute care hospital: is a hospital that does not meet the definition of a hospital ascribed in Section C. of Chapter II.~~

~~3. "Case mix index" means, for a given hospital, the quotient resulting from dividing the sum of all the diagnosis related grouping relative weighting factors in effect on January 1, 2005, for all category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Chapter X., by the total number of category of service 20 admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under Chapter X.~~

~~4. "Medicaid admissions" means State fiscal year 2007 hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the 2009 CHAP rate period, as defined in Section H.3 of Chapter XV., and contained within the Department's paid claims database, for recipients of medical assistance under Title XIX of the Social Security Act, excluding Medicare/Medicaid crossover admissions.~~

[MATERIAL REMOVED]

~~D. Rate reviews.~~

~~1. A hospital shall be notified in writing of the results of the payment determination pursuant to this Chapter.~~

~~2. Hospitals shall have a right to appeal pursuant to the provisions of Section C.2 of Chapter XXI.~~

XXXIII. Reserved. ~~Hospital Medicaid Stimulus Payments~~

~~12/09~~ ~~One-time payments shall be made to all eligible Illinois hospitals for inpatient Medicaid services occurring on or after December 10, 2009, in accordance with this Chapter. The total payment shall be the sum of the following payment methodologies:~~

~~A. Obstetrical Care Severity and Volume Stimulus Adjustment (OCSVSA)~~

~~1. Qualifying Criteria. With the exception of a large public hospital, a hospital designated as of July 1, 2009, by the Illinois Department of Public Health as a Perinatal Level III facility, that provided more that 2,000 Medicaid obstetrical days.~~

~~2. Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~i. The hospital's "Medicaid obstetrical days" and~~

~~ii. $175.00~~

~~B. Illinois Trauma Center Stimulus Adjustment (ITCA)~~

~~1. Qualifying Criteria. With the exception of a large public hospital, a hospital designated as of July 1, 2009, by the Illinois Department of Public Health as a Level I Trauma Center. For the purposes of this payment, hospitals located in the same city, that alternate their Level I Trauma Center designation in accordance with Section A.2. of Chapter XV, shall each be deemed eligible for the payment under this subsection.~~

~~2. Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~i. The hospital's "Medicaid inpatient days" and~~

~~ii. $22.00~~

~~C. Acute Care Across the Board Stimulus Adjustment (ABSA)~~

~~1. Qualifying Criteria. An Illinois hospital, with the exception of a large public hospital and a hospital identified in Section C.4. of Chapter II.~~

~~2. Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~i. The hospital's "Medicaid inpatient days" and~~

~~ii. $37.00~~

[MATERIAL REMOVED]

~~D. High Volume Medicaid Dependent Provider Stimulus Adjustment (HVMDA)~~

~~1. Qualifying Criteria. With the exception of a large public hospital and hospitals identified in Sections C.1., C.2. or C.4. of Chapter II, an Illinois hospital qualifying for designation under Section C. of Chapter VI for the rate year beginning October 1, 2009, and ending Sept. 30, 2010.~~

~~2. Payment. Hospitals meeting the qualifying criteria shall receive a supplemental inpatient payment equal to the product of:~~

~~i. The hospital's "Medicaid inpatient days" and~~

~~ii. $35.00~~

~~E. Adjustments and Limitations~~

~~1. The provisions of this Chapter shall be in effect as long as the payments under Chapters XXIII through XXIX remain in effect, but shall not extend beyond December 31, 2010.~~

~~2. No hospital shall be eligible for payment under this Chapter that:~~

~~i. Ceases operations prior to federal approval of, and adoption of administrative rules necessary to effect, payments under this Chapter; or~~

~~ii. Has filed for bankruptcy or is operating under bankruptcy protection under any Chapter of Title 11 of the United States Bankruptcy Code; or~~

~~iii. Discontinues providing a service recognized by one of the payments for which it qualifies; or~~

~~iv. Surrenders a license or designation recognized by one of the payments, or has a designation or certification revoked by the authorizing agency or entity;~~

~~F. Definitions. Unless otherwise indicated, the following definitions apply to the terms used in this section.~~

~~1. "Hospital" means any facility located in Illinois that is required to submit cost reports as mandated in Section G of Chapter VIII.~~

~~2. "Large public hospital" means a county-owned hospital, as described in Section A.1.a.i. of Chapter XVI, a hospital organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI, or a hospital owned or operated by a State agency, as described in Section A.7. of Chapter XVI.~~

[MATERIAL REMOVED]

~~3. "Medicaid inpatient days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005 as adjudicated by the Department through March 23, 2007.~~

~~4. "Medicaid obstetrical days" means, for a given hospital, the sum of days of inpatient hospital service provided to Illinois recipients of medical assistance under Title XIX of the federal Social Security Act, assigned a diagnosis related group code of 370 through 375, excluding days for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), for admissions occurring during State fiscal year 2005, adjudicated by the Department through March 23, 2007.~~

~~G. Rate Reviews.~~

~~1. A hospital shall be notified in writing of the results of the payment determination pursuant to this Chapter.~~

~~2. Hospitals shall have a right to appeal pursuant to the provisions of Section C.2 of Chapter XXI.~~

07/12 XL. Rate Reductions

07/14 For dates of service on or after July 1, 2012, all inpatient payment methodologies described in this attachment shall be reduced by 3.5%, for the rates that were otherwise in effect on July 1, 2012 and with implementation of this Attachment on July 1, 2014, except for payments to Long Term Acute Care Hospitals as defined under Chapter VIII(A)(3) which shall have their reimbursement rates reduced by 3.5% from rates that were otherwise in effect on October 1, 2010. Rates reductions defined in this chapter shall not apply to:

1. Rates or payments for hospital services delivered by a hospital defined as a safety net hospital under Section XV(K)(1) of this attachment.
2. Rates or payments for hospital services delivered by a hospital defined as a Critical Access Hospital that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F.
3. Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or state university that provides some or all of the non-federal share of such services.
4. Rates or payments for hospital inpatient services defined in Chapters XXXV through XXXIX.

07/14 5. Transitional payment authorized under Chapter XV.O. ~~89 Ill. Adm. Code 148.296.~~

07/12 XLI. Payment Limitations

A hospital that is located in a county of the State in which the Department of Healthcare and Family Services mandates some or all of its beneficiaries of the medical assistance program residing in the county to enroll in a care coordination program, shall not be eligible for any non-claims based payments for which it would otherwise be entitled to receive, unless the hospital is a coordinated care participating hospital no later than August 14, 2012, or 60 days after the first mandatory enrollment of a beneficiary in a coordinated care program. This payment limitation does not apply to inpatient payments defined in Chapters XXII through XXIX, or Chapters XXXV through XXXIX.

07/14~~11/13~~ XLIII. Reserved. ~~**Long Term Stay Hospital Per Diem Payments**~~

~~Conversion of static payments to per diem payments for long term stay hospitals.~~

~~A. Hospitals qualifying as a long term stay hospital on July 1, 2013, as defined in subsection C.4. of Chapter II, shall have their payments paid as a per diem rate add-on for all current claims beginning with admissions on or after November 16, 2013.~~

~~B. Each long term stay hospital's per diem add-on shall be the sum of its annual payment amounts in accordance with Chapter XV for state fiscal year 2011, divided by its covered days for dates of service in state fiscal year 2011 as contained in the Department's MMIS system.~~

~~C. For the payments due and payable in the period beginning July 1, 2013 through November 15, 2013, each long term stay hospital will be paid an annual amount prorated. The prorated amount shall be the product of the sum of their annual payment amounts in accordance with Chapter XV for state fiscal year 2011 multiplied by the quotient resulting from dividing 137 days by 365 days.~~

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07/14~~10/92~~ 1. Reimbursement for Hospital Outpatient and Clinic Services Prior to July 1, 2014.

a. Fee-For-Service Reimbursement

07/98 i. Reimbursement for hospital outpatient shall be made on a fee-for-service basis except for:

07/98 A. Those services that meet the definition of the Ambulatory Procedure Listing (APL) as described in subsection b of this Section;

07/98 B. End Stage Renal Disease Treatment (ESRDT) services, as described in subsection c. of this Section;

07/98 C Those services provided by a Critical Clinic Provider as described in subsection e. of this Section.

01/11 D. Those services provided by a Freestanding Emergency Center, as described in subsection j. of this Section.

07/14 ~~07/99~~ ii. Except for the procedures under the APL groupings described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens, as described in the annual obstetric and pediatric State plan. ~~Hospitals will be required to bill the Department utilizing specific service codes~~. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as non-hospital providers who bill fee-for-service.

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07/14 1.1. Reimbursement for Hospital Outpatient and Clinic Services Effective for Services on or after July 1, 2014.

a. Fee-For-Service Reimbursement

i. Reimbursement for hospital outpatient and clinic services shall be made on a fee-for-service basis except for:

A. ~~Those services that meet the definition of the Ambulatory Procedure Listing (APL)~~Services as described in subsection b. of this Section;

B. End Stage Renal Disease Treatment (ESRDT) services, as described in subsection c~~ge~~. of this Section;

~~C. Those services provided by a Critical Clinic Provider as described in subsection e. of this Section.~~

C.~~D.~~Those services provided by a Freestanding Emergency Center, as described in subsection h.~~j.~~ of this Section.

ii. Except for the services reimbursed ~~procedures~~ under the ~~APL groupings~~EAPG PPS, described in subsection (b) of this Section, fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens~~, as described in the annual obstetric and pediatric State plan. Hospitals will be required to bill the Department utilizing specific service codes.~~ However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as non-hospital providers who bill fee-for-service.

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[MATERIAL REMOVED]

~~07/98 [material removed]~~

~~07/98~~ ~~iv Outpatient Indigent Volume Adjustment Payment~~

~~A. Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois County with a population of over three million shall be eligible for an outpatient indigent volume adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Chapter and are calculated as follows:~~

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07/14 1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

b. EAPG PPS reimbursement. Reimbursement under EAPG PPS, described in subsection ~~(c.)~~, shall be all-inclusive for all services provided by the hospital, without regard to the amount charged by a hospital. Except as provided in subsection b.iii.~~(b)(3)~~, no separate reimbursement will be made for ancillary services or the services of hospital personnel.

i. Outpatient hospital services reimbursed through the EAPG PPS shall include:

A. Surgical ~~S~~services.

B. Diagnostic and therapeutic services or items directly related to the provision of a surgical procedure.

C. Emergency department services.

D. Observation services.

E. Psychiatric treatment services.

ii. Reserved. ~~Excluded from reimbursement under the EAPG PPS are outpatient hospital services reimbursed pursuant an alternative negotiated methodology for reimbursement that result in an expenditure which does not exceed the expenditure which would otherwise be made under the EAPG PPS reimbursement.~~

iii. Exceptions to all-inclusive EAPG PPS rate.

A. A hospital may bill separately for professional services of:

1. Professional services of a physician who provided direct patient care.

2. Chemotherapy services provided in conjunction with radiation therapy services.

3. Physical rehabilitation, occupational or speech therapy services provided in conjunction with an APG PPS reimbursed service.

4. Ancillary services not related to an outpatient visit. Ancillary services are diagnostic or therapeutic services provided as prescribed by a healthcare professional such as labs, x-ray, radiology and diagnostics.

B. For the purpose of subsection iii.A. ~~(iii)(A)~~, a physician means:

1. A physician salaried by the hospital. Physicians salaried by the hospital do not include radiologists, pathologists, nurse practitioners, or certified registered nurse anesthetists; no separate reimbursement will be allowed for such providers.

2. A physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care.

3. A group of physicians with a financial contract to provide emergency department care.

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[MATERIAL REMOVED]

~~07/95~~ ~~B. In order to ensure funding for the outpatient indigent volume adjustment payment, an indigent pool shall be created. The amount of money dedicated to this pool shall equal $200 million.~~

~~07/95~~ ~~C. Payments from the indigent pool, to individual eligible hospitals, shall be in an amount that is in proportion to the number of Medicaid outpatient services (as identified on claims submitted to the Illinois Department of Public Aid for payment) that the individual hospital provided to persons eligible for Medicaid divided by the total of all Medicaid outpatient services provided to persons eligible for Medicaid by all hospitals eligible to receive outpatient indigent volume adjustment payments. The service statistics used in this calculation shall reflect services provided during the most recently completed State fiscal year prior to the State fiscal year in which the payments are being made (SFY'94 utilization statistics for payments made in SFY'96). Payments under this subsection shall be made on a quarterly basis.~~

~~07/95~~ ~~D. Aggregate Medicaid reimbursement for all hospitals for Medicaid outpatient services (including outpatient indigent volume adjustment reimbursement) will not be allowed to exceed total allowable Medicaid outpatient costs for Medicaid outpatient services provided to Illinois Medicaid recipients. This test will be made annually. If the test against the upper limit finds that the upper limit was exceeded, the size of the outpatient indigent volume adjustment pool will be reduced by the amount in excess of the limit.~~

~~01/11~~ ~~v. Critical Access Hospital Rate Adjustment~~

~~Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485, Subpart F shall be eligible for an outpatient rate adjustment for services identified in subsections 1.b.i.A – 1.b.i.F., excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:~~

~~A. An annual distribution factor shall be calculated as follows;~~

~~1. The numerator of which shall be $33 million.~~

~~2. The denominator of which shall be the RY 2011 total outpatient cost coverage deficit calculated in accordance subsection 1.n., less the RY 2011 Rural Adjustment outpatient Payments calculated in accordance with subsection 1.n. plus the annual outpatient supplemental payment calculated in accordance with Section 32.~~

~~B. Hospital Specific Adjustment Value;~~

~~For each hospital qualified under this subsection v., the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in subsection v.A.2. of this section and the distribution factor calculated in v.A. of this section.~~

~~C. Final APL Rate Adjustment Values shall be the quotient of;~~

~~1. The Hospital Specific Adjustment Value identified in subsection v.B. of this Section divided by;~~

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c EAPG PPS payment. The reimbursement to hospitals for outpatient services provided on the same day shall be the product, rounded to the nearest hundredth, of the following:

i. The EAPG weighting factor of the EAPG to which the service was assigned by the EAPG grouper.

ii. The EAPG conversion factor, based on the sum of:

A. The product, rounded to the nearest hundredth, of:

1. the labor-related share;

2. the Medicare IPPS wage index; and

3. the applicable EAPG standardization amount.

B. The product, rounded to the nearest hundredth, of:

1. non-labor share; and

2. the applicable EAPG standardized amount.

iii. The applicable consolidation factor.

iv. The applicable packaging factor.

v. The applicable discounting factor.

vi. The applicable policy adjustment factors, as defined in subsection ~~(f.)~~, for which the service qualifies.

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~~2. The total outpatient services identified in subsections 1.b.i.A—1.b.i.F. excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the departments paid claims database as of December 31, 2010.~~

~~D. Non-State Government-owned provider adjustment~~

~~Final APL rates for hospitals identified as Non-State government-owned or operated providers in the state's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.~~

~~E. Applicability~~

~~The rates calculated in accordance with subsection v.A. of this Section shall be effective for dates of service beginning January 1, 2011and shall be adjusted each State fiscal year beginning July 1, 2011.~~

~~1. For State fiscal year 2011 the rate year shall begin January 1, 2011 and end June 30, 2011.~~

~~2. For State fiscal year 2012 and beyond the rate year shall be for dates of service beginning July 1 through June 30 of the subsequent year.~~

~~3. For purposes of this adjustment children's hospital identified in Attachment 4.19-A Chapter II.C.3.b., shall be combined with the corresponding general acute care parent hospital.~~

~~4. Beginning with State fiscal year 2012 and each subsequent state fiscal year thereafter, the adjustment to the FY 2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5.~~

~~01/11~~ ~~vi. No Year-End Reconciliation~~

~~With the exception of the retrospective rate adjustment described in 1.b.vi of this Section, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1.b.~~

~~01/11~~ ~~vii. Rate Adjustments~~

~~With respect to those hospitals described in Appendix to Attachments 3.1A and 3.1B, Section 2a.9a.1, the reimbursement rates described in 1.b.iv above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~

~~A. The reimbursement rates described in 1.b.iv above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~

~~B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~01/11~~ ~~viii. Hospitals described in Appendix to Attachments 3.1A and 3.1B, Sections 2a.9a.1 and 2a.9a.2, shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year.~~

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d. EAPG standardized amount. The standardized amount established by the Department as the basis for EAPG conversion factor differs based on the provider type:

i. County-operated large public hospital EAPG standardized amount. For a large public hospital, as defined at Chapter VII ~~XXXIV.b.~~ of Attachment 4.19-A, the EAPG standardized amount is determined in Chapter 33 of this Attachment.

ii. University-operated large public hospital EAPG standardized amount. For a large public hospital, as defined in at VII ~~XXXIV.b.~~ of Attachment 4.19-A, the EAPG standardized amount is determined in Chapter 33 ~~38~~ of this Attachment.

iii. Critical access hospital EAPG standardized amount. For critical access hospitals, that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F., the EAPG standardized amounts are determined separately for each critical access hospital such that:

A. Simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Chapter 32 of this Attachment, net of tax costs are equal to:

B. Estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

iv. Acute EAPG standardized amount.

A. Qualifying criteria. General acute hospitals and freestanding emergency centers, excluding providers in subsections .d.i. through d.iii. in this Section, freestanding psychiatric hospitals, psychiatric distinct part units, freestanding rehabilitation hospitals, and rehabilitation distinct part units.

B. The acute EAPG standardized amount is based on a single statewide amount determined such that:

1. Simulated EAPG payments, without rate reductions defined in Chapter 46 of this Attachment or policy adjustments defined in subsection f., using general acute hospital outpatient base period paid claims data, results in approximately a $75 million increase compared to:

2 The sum of general acute hospital base period paid claims data reported payments and allocated outpatient static payments.

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~~07/95~~ ~~c. Payment for outpatient end-stage renal disease treatment (ESRDT) services shall be:~~

~~07/95~~ ~~i. At the rate established by Medicare as of December 31, 2010~~

~~07/02~~ ~~ii. With respect to Illinois county-owned hospitals, as defined in Chapter II.C.8. of Attachment 4.19-AAppendix to Attachment 3.1A, the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:~~

~~A. The reimbursement rates described in this section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.~~

~~B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

~~iii. With the exception of the retrospective rate adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1 c.~~

~~07/95~~ ~~iv. County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.~~

~~07/13~~ ~~v. Effective July 1, 2013, hospitals and freestanding chronic dialysis centers will receive an add-on payment of $60 per treatment day to the rate described in c.i. above for outpatient renal dialysis treatments or home dialysis treatments provided to Medicaid recipients under Title XIX of the Social Security Act, excluding services provided to individuals eligible for Medicare.~~

~~Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient end-stage renal disease treatment services. The agency's fee schedule rate was set as of July 1, 2013 and is effective for services provided on or after that date. All rates are published on the Department's website in Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.~~

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v. Psychiatric EAPG standardized amount.

A. Qualifying criteria. Freestanding psychiatric hospitals and psychiatric distinct part units.

B. The psychiatric EAPG standardized amount is based on a single statewide amount, determined such that:

1. Simulated EAPG payments, without policy adjustments defined in subsection f. of this Chapter, using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data, results in payments ~~approximately~~ equal to the amount derived in subsection d.v.B.2. of this Chapter.

2. The sum of freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.

vi. Rehabilitation EAPG standardized amount.

A. Qualifying criteria. Freestanding rehabilitation hospitals and rehabilitation distinct part units.

B. The rehabilitation EAPG standardized amount is based on a single statewide amount, determined such that:

1. Simulated EAPG payments, without rate-reductions described in Chapter 46 of this Attachment or policy adjustments defined in subsection f. of this Chapter, using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data, results in payments approximately equal to:

2. The sum of freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period paid claims data reported payments and allocated outpatient static payments.

vii. Out-of-state non-cost reporting hospital EAPG standardized amount. For non-cost reporting hospitals, the EAPG standardized amount is $362.32, which is not wage adjusted.

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[MATERIAL REMOVED]

~~07/93~~ ~~d. Non Hospital-Based Clinic Reimbursement~~

~~i. County-Operated Outpatient Facility Reimbursement~~

~~07/02~~ ~~For county-operated outpatient facilities as defined in Appendix to Attachment 3.1-A, that do not qualify as either a Maternal and Child Health Program, managed care clinic, or as a Critical Clinic Provider, as described in subsection e. below, reimbursement for all services shall be on an all-inclusive per encounter rate basis, determined as follows:~~

~~A. Base Rate~~

~~The per encounter base rate shall be calculated as follows:~~

~~1. Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.~~

~~07/95~~ ~~2. The resulting quotient, as calculated in 1 above shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.~~

~~3. The resulting product as calculated in 2 above shall be added to the resulting quotient, as calculated in 1 above to determine the per encounter base rate.~~

~~07/95~~ ~~B. Supplemental Rate~~

~~1. The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.~~

~~07/95~~ ~~2. The direct supplemental service cost, as calculated in 1 above, shall be multiplied by the Medicare allowable overhead rate factor to calculate the supplemental overhead cost per encounter.~~

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e. Discounting factor. The applicable discounting factor is based on the discounting flags designated by the EAPG grouper under default EAPG settings:

i. The discounting factor will be 1.0000, if the following criteria are met:

A. The service has not been designated with a Bilateral Procedure Discounting flag, Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or

B. The service has not been designated with a Bilateral Procedure Discounting flag and has been designated with a Multiple Procedure Discounting flag by the EAPG grouper under default EAPG settings and the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

ii. The discounting factor will be 0.5000 if the following criteria are met:

A. The service has been designated with a Multiple Procedure Discounting flag, Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day; and

B. The service has not been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings.

iii. The discounting factor will be 0.7500 if the following criteria are met:

A. The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B. The service has been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; and if the Multiple Procedure Discounting flag is present, the service does not have the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

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~~07/95~~ ~~3. The resulting product, as described in 2 shall be the per encounter supplemental rate.~~

~~C. Final Rate~~

~~07/95~~ ~~1. The per encounter base rate, as described in d. i. A shall be added to the per encounter supplemental rate as calculated in d.1.B to determine the per encounter final rate.~~

~~07/95~~ ~~2. The per encounter final rate shall be adjusted in accordance with D. below.~~

~~D. Rate Adjustments~~

~~07/95~~ ~~Adjustments to the per encounter final rate as derived in C. above shall be calculated as follows:~~

~~07/98~~ ~~1. Effective October 1, 1992, the final reimbursement rates described in C. above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. Effective July 1, 1998, the final rate shall be no less than $147.09 per encounter.~~

~~2. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

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iv) The discounting factor will be 1.5000 if the following criteria are met:

A) The service has been designated with a Bilateral Procedure Discounting flag by the EAPG grouper under default EAPG settings; and

B) The service has not been designated with a Multiple Procedure Discounting flag, the Repeat Ancillary Discounting flag or Terminated Procedure Discounting flag by the EAPG grouper under default EAPG settings; or if the Multiple Procedure Discounting flag is present, the service has the highest EAPG weighting factor among other services with a Multiple Procedure Discounting flag provided on the same day.

f. Policy adjustments. Claims for services by providers that meet certain criteria shall qualify for further adjustments to payment. If a claim qualifies for more than one policy adjustment, then the EAPG PPS payment will be multiplied by both factors.

i. Safety Net hospital. Qualifying criteria

A. The service is described in b.i.of this Chapter, excluding Medicare crossover claims.

B. The hospital is a Safety Net hospital, as defined in Chapter XV. K. of Attachment 4.19-A, that is not:

1. A critical access hospital, that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F

2. A large public hospital, as defined at Chapter VII ~~XXXIV.b.~~ of Attachment 4.19-A.

C. Policy adjustment factor effective State fiscal year 2015 and 2016 is 1.3218 ~~1.3252~~.

ii. High Outpatient Volume hospital. Qualifying criteria

A. The service is described in ~~(b)(i)~~ b.1. of this Chapter, excluding Medicare crossover claims.

B. The hospital is a High Outpatient Volume hospital, as defined in subsection d.iv., ~~of this subsection~~ that is not:

1. A critical access hospital that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F.

2. A large public hospital, as defined at Chapter VII ~~XXXIV.b.~~ of Attachment 4.19-A.

3. A Safety Net hospital, as defined in Chapter XV. K. of Attachment 4.19-A .

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~~07/02~~ ~~ii. County-operated outpatient facilities shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this section.~~

~~07/02~~ ~~iii. Services are available to all clients in geographic areas in which a county-owned hospital or a county-operated outpatient facility is located.~~

~~09/97~~ ~~e. Critical Clinic Providers~~

~~i. Effective for services provided on or after September 27, 1997, clinics owned and operated by a county with a population of over three million, that are within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection .e. requires that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:~~

~~A. 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,~~

~~B. 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,~~

~~C. 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,~~

~~D. 3600 for reimbursement provided during the facility's cost reporting year ending during 2001,~~

~~E. 4200 for reimbursement provided during the facility's cost reporting year ending during 2002,~~

~~ii. Reimbursement for all services provided by a Critical Clinic Provider shall be on an all-inclusive per encounter rate which shall equal reported direct costs of the Critical Clinic Provider for the facility's cost reporting period ending in 1995, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.~~

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C. A High Outpatient Volume hospital for which the high outpatient volume is at least:

1. One and one -half standard deviations above the mean regional high outpatient volume, or

2. One and one-half standard deviations above the mean statewide high outpatient volume.

D. Policy adjustment factor effective State fiscal year 2015 and 2016 is 1.3218 ~~1.3252~~.

iii. Crossover Adjustment Factor

A. Acute EAPG standardized amounts, as defined in subsection d.iv., shall be reduced by a Crossover Adjustment factor such that:

1. The absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment factor to simulated EAPG payments, including Policy Adjustments, using general acute hospital outpatient base period paid claims data, is equal to:

2. The difference of; total simulated EAPG payments using general acute hospital outpatient crossover paid claims data, and general acute hospital outpatient crossover paid claims data total reported Medicaid net liability.

B. Crossover Adjustment Factor effective State fiscal year 2015 and 2016 is 0.98912.

iv. If a claim does not qualify for a Policy Adjustment described in subsection f.i. through f.iii. of this Section, the policy adjustment factor is 1.0.

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~~iii. Critical Clinic Providers, as described in this subsection .e., shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection .e.~~

~~iv. The reimbursement rates described in this subsection .e. shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.~~

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g. Payment for outpatient end-stage renal disease treatment (ESRDT) services shall be:

i. At the rate established by Medicare as of December 31, 2010

ii. With respect to Illinois county-owned hospitals, as defined in Chapter II.C.8. of Attachment 4.19-A~~Appendix to Attachment 3.1A~~, the reimbursement rate described above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A. The reimbursement rates described in this section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

iii. With the exception of the retrospective rate adjustment described above, no year-end reconciliation is made to the reimbursement rates calculated under this Section 1.c.

iv. County-owned and State-owned hospitals shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

07/13 v. Effective July 1, 2013, hospitals and freestanding chronic dialysis centers will receive an add-on payment of $60 per treatment day to the rate described in c.i. above for outpatient renal dialysis treatments or home dialysis treatments provided to Medicaid recipients under Title XIX of the Social Security Act, excluding services provided to individuals eligible for Medicare.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient end-stage renal disease treatment services. The agency's fee schedule rate was set as of July 1, 2013 and is effective for services provided on or after that date. All rates are published on the Department's website in Practitioner Fee Schedule located at www.hfs.illinois.gov/feeschedule/.

~~h. Updates to EAPG PPS reimbursement. The Department may annually review the components as listed in subsection (c) of this Section and make adjustments as needed.~~

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07/98 ~~f. Special Reimbursement Requirements for Services Provided in Hospital Emergency Room and Clinic Settings.~~

~~i. When emergency room services are provided to clients, the hospital is required to code any fee-for-service claims with the emergency room place of service.~~

07/03 ~~g. Hospital-Based Organized Clinic Reimbursement.~~

~~i. With respect to hospital-based organized clinics that qualify as Maternal and Child Health Clinics, payment shall be made in accordance with Section 1(a) (iv) of this attachment.~~

~~ii. With respect to all other hospital-based organized clinics, payment shall be in accordance with the fee-for-service reimbursement described in Section 1 of this attachment.~~

07/03 ~~h. Reserved.~~

07/98 ~~i. Psychiatric clinic reimbursement~~

~~Reimbursement shall be made under the federally qualified health center methodology if the clinic meets the criteria as an FQHC. Otherwise the clinic shall be reimbursed as an encounter rate clinic.~~

01/11 h.~~j.~~ Freestanding Emergency Centers

A Freestanding Emergency Center (FEC), a facility that provides comprehensive emergency treatment services 24 hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Emergency Medical Services (EMS) Systems Act as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the EMS Systems Act in effect for the jurisdiction in which it is located, is eligible to enroll for reimbursement of emergency services. Reimbursement for the emergency services provided in an FEC shall be made at the applicable ~~APL group~~ EAPG rate identified in subsection b. of this Section. Payment for salaried physician services performed in conjunction with an APL procedure shall be made in accordance with subsection b. of this Section.

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i.~~j~~) Outpatient Physical Rehabilitation~~Rehabilitative~~ Services ~~Maximum reimbursement rates~~.

The maximum reimbursement rate ~~shall be~~:

i. For outpatient ~~I~~physical rehabilitation services~~, including physical, occupational and speech therapies,~~ provided by a hospital —(paid per visit and limited to one visit per day):

a. That is a children's hospital, as defined in Chapter II.C.3. of Attachment 4.19-A, ~~paragraph 148.25(d)(3)(A), enrolled with the Department to provide outpatient physical rehabilitation~~ the rate shall be $130.00.

b. Enrolled with the Department to provide outpatient physical rehabilitation, the rate shall be $130.00.

c. Not enrolled with the Department to provide outpatient physical rehabilitation, the rate shall be $115.00.

ii. For all other physical, occupational and speech therapy services ~~(paid per quarter hour)~~, the reimbursement rate shall be in accordance with the methods and standards described in Attachment 4.19-B, Item 14. ~~as published in fee schedules on the Department's website.~~

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k~~i~~) Definitions

"Aggregate ancillary cost-to-charge ratio" means the ratio of each hospital's total ancillary costs and charges reported in the Medicare cost report, excluding special purpose cost centers and the ambulance cost center, for the cost reporting period matching the outpatient base period claims data. Aggregate ancillary cost-to-charge ratios applied to SFY 2011 outpatient base period claims data will be based on fiscal year ending 2011 Medicare cost report data.

"Consolidation factor" means a factor of 0 percent applicable for services designated with a Same Procedure Consolidation Flag or Clinical Procedure Consolidation Flag by the EAPG grouper under default EAPG settings.

"Default EAPG settings" means the default EAPG grouper options in 3M's Core Grouping Software for each EAPG grouper version.

"EAPG" means Enhanced Ambulatory Patient Groups, as defined in the EAPG grouper, which is a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

"EAPG grouper" means the most recently released version of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by 3M Health Information Systems, available to the Department as of January 1 of the calendar year during with the discharge occurred; except, for the calendar year beginning January 1, 2014, EAPG grouper means the version 3.7 of the EAPG software.

"EAPG PPS" means the EAPG prospective payment system as described in this Section.

"EAPG weighting factor" means, for each EAPG, the product, rounded to the nearest ten-thousandth, of (i) the national weighting factor, as published by 3M Health Information Systems for the EAPG grouper, and (ii) the Illinois experience adjustment.

"Estimated cost of outpatient base period claims data" means the product of (i) outpatient base period paid claims data total covered charges, (ii) the critical access hospital's aggregate ancillary cost-to-charge ratio, and (iii) a rate year cost inflation factor.

"Freestanding Emergency Center (FEC)" means a facility that provides comprehensive emergency treatment services 24 hours per day, on an outpatient basis, and has been issued a license by the Illinois Department of Public Health under the Emergency Medical Services (EMS) Systems Act as a freestanding emergency center, or a facility outside of Illinois that meets conditions and requirements comparable to those found in the EMS Systems Act in effect for the jurisdiction in which it is located.

"High outpatient volume" means the number paid outpatient claims ~~services~~ described in subsection b.i. provided during the high volume outpatient base period paid claims data.

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~~j. Pediatric Outpatient Adjustment Payments~~

~~Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals described in Section C.8 of Chapter II, and hospitals organized under the University of Illinois Hospital Act, as described in Section C.8 of Chapter II, for outpatient services occurring on or after July 1 1998 , in accordance with this Section.~~

~~i. To qualify for payments under this Section, a hospital must:~~

~~A. Be a children's hospital, as defined in Section c.3.of Chapter II and,~~

~~B. Have a Pediatric Medicaid Outpatient Percentage greater than 80% during the Pediatric Outpatient Adjustment Base Period.~~

~~7/02~~ ~~ii. Hospitals qualifying under this Section shall receive the following amounts for the Pediatric Outpatient Adjustment Rate Year:~~

~~A. For Illinois hospitals with a Medicaid Inpatient Utilization Rate (MIUR) that is less than 75% the product of;~~

~~1. The hospital's MIUR plus one, multiplied by,~~

~~2. The number of Pediatric Adjustable Outpatient Services, multiplied by~~

~~3. $169~~

~~04/09~~ ~~B. For Illinois hospitals with an MIUR that is greater than or equal to 75% the product of;~~

~~1. One and one-half the hospital's MIUR plus one, multiplied by,~~

~~2. The number of Pediatric Adjustable Outpatient Services, multiplied by~~

~~3. $305~~

~~7/02~~ ~~C. For out of State cost reporting hospitals with an MIUR that is less than 75 percent, the product of:~~

~~1. The hospital's MIUR plus 1.15, multiplied by,~~

~~2. The number of Pediatric Adjustable Outpatient Services, multiplied by,~~

~~3. $169~~

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i. Definitions Continued

"High volume outpatient base period paid claims data" means state fiscal year 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2015 and 2016. For subsequent dates of service, the State fiscal year ending 30 months prior to the beginning of the calendar year during which the service is provided.

"Illinois experience adjustment" means for the calendar year beginning January 1, 2014, a factor of 1.0; for subsequent calendar years, means the factor applied to 3M EAPG national weighting factors when updating EAPG grouper versions determined such that the arithmetic mean EAPG weighting factor under the new EAPG grouper version is equal to the arithmetic mean EAPG weighting factor under the prior EAPG grouper version using outpatient base period claims data.

"Labor-related share" means that portion of the statewide standardized amount that is allocated in the EAPG PPS methodology to reimburse the costs associated with personnel. The Labor-related share for a hospital is 0.60 effective July 1, 2014.

"Mean regional high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections b.i.A. through D. of this Section, provided by hospitals within a region, based on outpatient base period paid claims data.

"Mean statewide high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections b.i.A. through D. of this Section, provided by hospitals within the state, based on outpatient base period paid claims data.

"Medicare IPPS wage index" means for in-state providers and out-of-state Illinois Medicaid cost reporting providers, the wage index used for inpatient reimbursement is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system hospital post-reclass wage index effective October 1, 2012. For out-of-state non-cost reporting providers, the wage index used to adjust the EAPG standardized amount shall be a factor of 1.0 effective July1, 2014.

"Non-labor share" means the difference resulting from the labor-related share being subtracted from 1.0.

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~~7/02~~ ~~iii~~ ~~In addition to the reimbursement rates described in subsection ii above, hospitals that have an MIUR that is greater than or equal to 80% shall receive an additional $229,740 during the Pediatric Outpatient Adjustment Rate Year.~~

~~7/02~~ ~~iv.~~ ~~Adjustments under this Section shall be paid at least quarterly.~~

~~v.~~ ~~No less than annually, the Department will assess the adequacy of the qualifying criteria established in the Section. If the Department determines that existing qualifying criteria do not adequately address pediatric outpatient access, the Department will amend this Section within 90 days of such a determination.~~

~~04/09~~ ~~vi.~~ ~~Definitions~~

~~A.~~ ~~A Medicaid Inpatient Utilization Rate or "MIUR", as used in this Section, has the meaning as defined in~~

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i. Definitions Continued

"Outpatient base period paid claims data" means State fiscal year 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12 months of outpatient paid claims data to be identified by the Department.

"Outpatient crossover paid claims data" means State fiscal year 2011 outpatient Medicaid/Medicare dual eligible fee-for-service paid claims data, excluding renal dialysis claims and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2015, 2016 and 2017; for subsequent dates of service, the most recently available adjudicated 12-months of outpatient paid claims data to be identified by the Department.

"Packaging factor" means a factor of 0 percent applicable for services designated with a Packaging Flag by the EAPG grouper under default EAPG settings plus EAPG 430 (CLASS I CHEMOTHERAPY DRUGS), EAPG 435 (CLASS I PHARMACOTHERAPY), EAPG 495 (MINOR CHEMOTHERAPY DRUGS), EAPG 496 (MINOR PHARMACOTHERAPY), and EAPGs 1001-1020 (DURABLE MEDICAL EQUIPMENT LEVEL 1-20), and non-covered revenue codes defined in the Handbook for Hospital Services.

"Rate year cost inflation factor" means the cost inflation from the midpoint of the outpatient base period paid claims data to the midpoint of the rate year based on changes in Centers for Medicare and Medicaid Services (CMS) input price index levels. For critical access hospital rates effective SFY 2015, the rate year cost inflation factor will be based on changes in CMS input price index levels from the midpoint of SFY 2011 to SFY 2015.

"Total covered charges" means the amount entered for revenue code 001 in column 53 (Total Charges) on the Uniform Billing Form (form CMS 1450), or one of its electronic transaction equivalents.

"Region" means, for a given hospital, the rate region in which the hospital is located as defined below.

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~~Section C.8.e, Chapter VI, or Attachment 4.19-A, in effect for the rate period October 1, 1996, through September 30, 1997.~~

~~B. "Pediatric Adjustable Outpatient Services" means the number of outpatient services, excluding procedure code 0080, adjudicated through a UB92 billing form and grouped through the Hospital Ambulatory Care Groupings, as defined in Section 148.140.b1 during the Pediatric Outpatient Adjustment Base Period. For a hospital which includes a facility devoted exclusively to caring for children, that is separately licensed as a hospital by a municipality, Pediatric Adjustment Outpatient Services will include psychiatric services (categories of service 27 or 28) for children less than 18 years of age, that are billed through the affiliated general care hospital.~~

~~C. "Pediatric Medicaid Outpatient Percentage" means a percentage that results from the quotient of the total Medicaid Pediatric Adjustable Outpatient Services for persons less than 18 years of age divided by the total Medicaid Pediatric Adjustable Outpatient Services for all persons, during the Pediatric Outpatient Adjustment Base Year.~~

~~D. "Pediatric Outpatient Adjustment Base Period" means all services billed to the Department, excluding procedure code 0080, with State Fiscal Year 1996 dates of services that were adjudicated by the Department on or before March 31, 1997.~~

~~E. "Pediatric Outpatient Adjustment Rate Year" means State Fiscal Year 1998 and each State Fiscal Year hereafter.~~

~~04/09~~ ~~vii. For hospitals qualifying for payments under this Section for adjustment periods occurring in State fiscal year 2009, total payments will equal the sum of amounts calculated under the methodologies described in this Section and shall be paid to the hospital during the Pediatric Outpatient Adjustment Rate year.~~

~~07/98~~ ~~k. Appeals for Pediatric Outpatient Adjustment Payments.~~

~~The Department shall make Pediatric Outpatient Adjustment payments in accordance with Section 1.j. above. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for~~

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These geographic regions, comprised of counties, are used in the Policy adjustments described in 1.1 f. ii. of this attachment and are defined as follows:

REGION 1 - NORTHWESTERN

Illinois Counties:

Boone	Bureau	Carroll	DeKalb	Fulton
Henderson	Henry	JoDaviess	Knox	LaSalle
Lee	Marshall	Mercer	Ogle	Peoria
Putnam	Rock Island	Stark	Stephenson	Tazewell
Warren	Whiteside	Winnebago	Woodford	

Out of State Counties:

Clinton, IA	Des Moines, IA	Dubuque, IA	Jackson, IA
Johnson, IA	Louisa, IA	Muscatine, IA	Scott, IA
Dane, WI	LaFayette, WI	Grant, WI	Green, WI
Rock, WI			

REGION 2 - CENTRAL

Illinois Counties:

Adams	Brown	Calhoun	Cass	Champaign
Christian	Clark	Coles	Cumberland	DeWitt
Douglas	Edgar	Ford	Greene	Hancock
Iroquois	Jersey	Livingston	Logan	Macon
Macoupin	Mason	McDonough	McLean	Menard
Montgomery	Morgan	Moultrie	Piatt	Pike
Sangamon	Schuyler	Scott	Shelby	Vermilion

Out of State Counties:

Benton, IN	Marion, IN	Newton, IN	Vigo, IN
Vermillion, IN	Warren, IN	Clark, MO	Lewis, MO
Lincoln, MO	Marion, MO	Pike, MO	Ralls, MO

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~~payments under Section 1.j. of this attachment, if it is believed that technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification under Section 1.j. of this attachment, and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request or review.~~

~~01/01~~ ~~l. Not with standing the provisions set forth in Chapter I, Section b., Ambulatory Surgical Treatment Centers, the changes described in this Section I., shall be effective January 1, 2001. Payments for hospital outpatient services and ambulatory surgical treatment services shall not exceed charges to the Department. This payment limitation shall not apply to government owned or operated hospitals described in Chapter II.C.8, or children's hospitals described in Chapter II.C.3.~~

~~08/01~~ ~~m. Transplant Care~~

~~Hospitals performing outpatient adult and pediatric stem cell transplants must be a part of a certified inpatient program and must have been in operation for at least two years with at least twelve outpatient stem cell transplant procedures per year in the past two years. Hospitals must meet the inpatient applicable transplant survival rates as supported by the Kaplan-Meier method or other method accepted by the Department, which includes a one-year survival rate of 50 percent for outpatient stem cell transplant patients.~~

~~Hospital reimbursement for stem cell transplants provided on an outpatient basis is an all-inclusive rate, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public for the same procedure for 50 consecutive days of care which includes a maximum of seven days prior to transplant for infusion of chemotherapy.~~

~~The Department will cover outpatient stem cell transplants, provided to United States citizens or aliens permanently residing in the United States under color of law pursuant to 42 *U.S.C.* 139a(a) and 1396b(v).~~

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

These geographic regions, comprised of counties, are used in the Policy adjustments described in 1.1 f. ii. of this attachment and are defined as follows:

REGION 3 - SOUTHERN

Illinois Counties:

Alexander	Bond	Clay	Clinton	Crawford
Edwards	Effingham	Fayette	Franklin	Gallatin
Hamilton	Hardin	Jackson	Jasper	Jefferson
Johnson	Lawrence	Madison	Marion	Massac
Monroe	Perry	Pope	Pulaski	Randolph
Richland	Saint Clair	Saline	Union	Wabash
Washington	Wayne	White	Williamson	

Out of State Counties:

Gibson, IN	Knox, IN	Vanderburgh, IN	Sullivan, IN
Crittenden, KY	Livingston, KY	McCracken, KY	Posey, KY
Union, KY	Cape Girardeau, MO	City of St. Louis, MO	Jefferson, MO
Mississippi, MO	Perry, MO	St. Charles, MO	St. Louis, MO
Ste. Genevieve, MO	Scott, MO		

REGION 4 – COOK COUNTY

REGION 5–COOK COLLAR COUNTIES

DuPage	Grundy	Kane	Kankakee	Kendall
Lake	McHenry	Will		

Out of State Counties:

Lake, IN	Milwaukee County, WI	Walworth, WI	Kenosha, WI

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[MATERIAL REMOVED]

~~n. Rural Adjustment Payments - Outpatient Component~~

~~a. Qualifying criteria: Rural Adjustment Payments shall be made to all qualifying general acute care hospitals which are designated as a Critical Access Hospital or a Necessary Provider, as defined by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F, as of the first day of July in the Rural Adjustment Payment rate period.~~

~~b. Rural Adjustment Rates:~~

~~i. Outpatient component: For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows;~~

~~A. Total outpatient payments, as defined in subsection (d)(ii) of this section, shall be divided by the total outpatient services, as described in subsection (d)(iii) of this section, to derive an outpatient payment per service unit.~~

~~B. Total outpatient charges, associated with outpatient services, as defined in subsection (d)(iii) of this section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(i) of this section, to derive total outpatient cost.~~

~~C. Total outpatient costs, as defined in subsection (b)(i)(B) of this section, are divided by the total outpatient services, as described in subsection (d)(iii) of this section to derive an outpatient cost per service unit.~~

~~D. Outpatient payment per service unit, as defined in subsection (b)(i)(A) of this section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(i)(c) of this section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.~~

~~E. Outpatient cost coverage deficit per service unit, as described in subsection (b)(i)(d) of this section, shall be multiplied by the total outpatient services, as described in subsection (d)(iii) of this section, to derive a total hospital specific outpatient cost coverage deficit.~~

~~F. The outpatient cost coverage deficits, as described in subsection (b)(i)(E) of this section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.~~

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[MATERIAL REMOVED]

~~ii. Payment Methodology: A $7 million total pool shall be allocated to the program, and proportioned between inpatient services Attachment 4.19-A (I)(N)(2)(b) and outpatient services as follows:~~

~~A. The total outpatient cost coverage deficit as described in subsection (b)(i)(F) of this section, is added to the total inpatient cost coverage deficit as described in Attachment 4.19-A (I)(N)(2)(a)(vi), to derive a total Rural Adjustment Payment base year deficit.~~

~~B. The outpatient pool allocation percentage shall be the quotient, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(i)(D) of this section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in (b)(ii)(F) of this section.~~

~~C. Outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(ii)(B) of this section, multiplied by the $7 million pool, as described in (b)(ii) of this section.~~

~~D. An outpatient residual cost coverage factor shall be the quotient, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(ii)(c) of this section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(i)(F) of this section.~~

~~E. Hospital specific outpatient cost coverage adjustment amount, shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(ii)(D) of this section, multiplied by the hospital specific outpatient cost coverage deficit, as described in subsection (b)(i)(E) of this section.~~

~~c. Payment to a Qualifying Hospital~~

~~i. The total annual adjustment amount to a qualified hospital shall be the outpatient cost coverage adjustment amount, as described in subsection (b)(ii)(E) of this section.~~

~~ii. The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(iv) of this section on at least a quarterly basis.~~

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[MATERIAL REMOVED]

~~d. Definitions.~~

~~i. "Hospital cost-to-charge ratio", means the quotient, the numerator of which is the cost as reported on Form HCFA 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form HCFA 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, for SFY 2004 the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.~~

~~ii. "Outpatient Payments", shall mean all payments associated with total outpatient services provided, as described in subsection (d)(iii) of this section, and all quarterly adjustment payments paid, as described in the State Plan.~~

~~iii. "Total Outpatient Services" means the number of outpatient services provided during the Rural Adjustment Payment base year, to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.~~

~~iv. Rural Adjustment Payment base year" means for the Rural Adjustment Payment rate period beginning October 1, 2002, State fiscal year 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, State fiscal year 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.~~

~~v. "Rural Adjustment Payment Rate Period" means, beginning October 1, 2002, the 9 month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003 the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~

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[MATERIAL REMOVED]

~~c. Medicaid Outpatient Utilization Rate (MOUR) Adjustment Payments.~~

~~a. Qualifying criteria: Medicaid outpatient utilization rate (MOUR) adjustment payments, as described in subsection b. of this Section, shall be made to an Illinois hospital, excluding:~~

~~i. A hospital provider that is a State agency, a State university, or a county with a population of over 3,000,000.~~

~~ii. A hospital provider that is a county with a population of less than 3,000,000 or a township, municipality, hospital district, or any other local governmental unit.~~

~~iii. A hospital provider whose hospital does not charge for its services.~~

~~iv. A hospital provider whose hospital is licensed by the Department of Public Health as a psychiatric hospital.~~

~~v. A hospital provider whose hospital is licensed by the Department of Public Health as a rehabilitation hospital.~~

~~vi. A hospital provider whose hospital is not a psychiatric hospital, rehabilitation hospital, or a children's hospital and has an average length of inpatient stay greater that 25 days.~~

~~b. MOUR adjustment.~~

~~i. Each qualifying hospital will receive a payment equal to the product of:~~

~~A. The quotient of:~~

~~1. The hospital's Medicaid outpatient charges in the MOUR base period,~~

~~2. Divided by the greater of the hospital's MOUR or 0.016 and~~

~~B. 0.0245.~~

~~ii. For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in b.1 shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed.~~

~~iii. Payments will be the lesser of the calculation described in subsection bi or bii of this section or $6,750,000.~~

~~05/01/04~~ ~~c. Payment to a Qualifying Hospital.~~

~~i. For the MOUR adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection b. of this Section multiplied by a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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[MATERIAL REMOVED]

~~ii. For the MOUR adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection b. of this Section and shall be paid to the hospital in four equal installments on or before the latter of July 15, 2004, October 15, 2004, January 14, 2005, or 75 days after federal approval of this State plan amendment.~~

~~iii. No payments will be made under this reimbursement methodology after August 31, 2005.~~

~~d. Definitions.~~

~~i. "Total outpatient charges" means, for a given hospital the gross outpatient revenue as reported on form CMS 2552-96, Worksheet G-2, Part I, row 25, column 2, for hospital fiscal years ending in calendar year 2001 as filed in the March 2003 release of the Healthcare Cost Reporting Information System (HCRIS). If information was not available for hospitals on the HCRIS the Department may obtain the gross outpatient charges from any source available, including but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

~~ii. "MOUR base period" means the twelve month period beginning on July 1, 2000, and ending on June 30, 2001.~~

~~iii. "MOUR adjustment period" means, beginning June 1, 2004, the one month period beginning on June 1, 2004 and ending June 30, 2004 and beginning July 1, 2004, the 12 month period beginning July 1 of the year and ending June 30 of the following year.~~

~~iii. "MOUR," for a given hospital, means the ratio of Medicaid outpatient charges to total outpatient charges.~~

~~iv. "Medicaid outpatient charges" means, for a given hospital, the sum of charges for ambulatory procedure listing services as described in Section 1.b., excluding charges for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover charges), as tabulated from the Department's paid claims data for services occurring in the MOUR base year that were adjudicated by the Department through September 12, 2003.~~

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[MATERIAL REMOVED]

~~v. "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

~~e. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for payments under this Section o. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

~~p. Outpatient Service Adjustment Payments.~~

~~a. Qualifying criteria: Outpatient service adjustment payments, as described in subsection b. of this section, shall be made to all Illinois hospitals excluding:~~

~~i. County-owned hospitals as described in Attachment 4.19-A, Chapter XVI, Section A.1.a.i.~~

~~ii. Hospitals organized under the University of Illinois Hospital Act, as described in Attachment 4.19-A, Chapter XVI, section A.1.a.ii.~~

~~iii. A hospital owned or operated by a state agency, as described in Attachment 4.19-A, Chapter XVI, section A.7.~~

~~b. Outpatient services adjustment payments.~~

~~i. An average hospital specific outpatient service rate for the outpatient service base period will be calculated by taking the total payments for outpatient services divided by total outpatient services.~~

~~ii. The average hospital specific outpatient service rate will be multiplied by 0.755 and then multiplied by the outpatient services.~~

~~iii. For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in bii. shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~

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[MATERIAL REMOVED]

~~iv. Outpatient service adjustment payments will be the lesser of the amount determined in subsection b.ii or b.iii of this section or $3,000,000.~~

~~c. Payment to a qualifying hospital.~~

~~i. For the outpatient service adjustment period occurring in State fiscal year 2004, total annual payments will equal the methodologies described in subsection b. of this Section multiplied by a fraction, the numerator of which is 53 and the denominator of which is 365.~~

~~ii. For the outpatient service adjustment occurring in State fiscal year 2005, total annual payments will equal the methodologies described in subsection b. of this Section and shall be paid to the hospital in four equal installments on or before the latter of July 15,2004, October 15, 2004, January 14,2005, and April 15, 2005, or 75 days after federal approval of the State plan amendment.~~

~~iii. No payments will be made under this reimbursement methodology after August 31,2005.~~

~~d. Definitions~~

~~i. "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

~~ii. "Outpatient service base period" means the twelve-month period beginning on July 1, 2000, and ending on June 30, 2001.~~

~~iii. "Outpatient service adjustment period" means, beginning June 1, 2004, the one-month period beginning on June 1, 2004, and ending June 30, 2004, and beginning July 1, 2004, the twelve-month period beginning July 1 of the year and ending June 30 of the following year.~~

~~iv. "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 1.b., excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/-Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient service base period that were adjudicated by the Department through September 12, 2003.~~

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[MATERIAL REMOVED]

~~e. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for payments under this Section p. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

~~q. Outpatient Rural Hospital Adjustment Payments~~

~~a. Qualifying criteria: Illinois rural hospitals, as described in Attachment 4.19-A, Chapter XVI, section B.3.~~

~~i. County-owned hospitals as described in Attachment 4.19-A, Chapter XVI, section A.1.a.i.~~

~~ii. Hospitals organized under the University of Illinois Hospital Act, as described in Attachment 4.19-A, Chapter XVI, section A.1.a.ii.~~

~~iii. A hospital owned or operated by a State agency, as described in Attachment 4.19-A, Chapter XVI, section A.7.~~

~~b. Outpatient rural adjustment payments.~~

~~i. Each qualifying hospital's outpatient services for the outpatient rural base period will be divided by the sum of all qualifying hospitals' outpatient services for the outpatient rural base period.~~

~~ii. This ratio will be multiplied by $14,500,000 to determine the hospital's outpatient rural adjustment payment.~~

~~iii. For a hospital that files a combined Medicaid cost report with another hospital after January 1, 2001, and then subsequently closes, the payment described in b.ii. shall be multiplied by a fraction, the numerator of which is the number of occupied bed days attributable to the open hospital and the denominator of which is the sum of the occupied bed days of each open hospital and each closed hospital.~~

~~c. Payment to a qualifying hospital.~~

~~i. For the outpatient service adjustment period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection b. of this Section multiplied by a fraction, the numerator of which is 53 and the denominator of which is 365.~~

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[MATERIAL REMOVED]

~~ii. For the outpatient rural adjustment period occurring in State fiscal year 2005, total payments will equal the methodologies described in subsection b. of this Section and shall be paid to the hospital in four equal installments on or before the latter of July 15, 2004, October 15, 2004, January 14, 2005, and April 15,2005, or 75 days after federal approval of the State plan amendment.~~

~~iii. No payments will be made under this reimbursement methodology after August 31, 2005.~~

~~d. Definitions.~~

~~i. "Occupied bed days" means the sum of the number of days that each bed was occupied by a patient for all beds during calendar year 2001, as reported by each hospital on the Annual Survey of Hospitals conducted by the Department of Public Health. If the sum of a hospital's occupied bed days is not reported on the Annual Survey of Hospitals, then the Department of Public Aid may obtain the sum of occupied bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.~~

~~ii. "Outpatient rural base period" means the twelve-month period beginning on July 1, 2000, and ending on June 30, 2001.~~

~~iii. "Outpatient rural adjustment period" means, beginning June 1, 2004, the one-month period beginning on June 1, 2004 and ending June 30, 2004, and beginning July 1, 2004, the twelve-month period beginning July 1 of the year and ending June 30 of the following year.~~

~~iv. "Outpatient services" means, for a given hospital, the sum of ambulatory procedure listing services as described in Section 1.b., excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/-Medicare crossover services), as tabulated from the Department's paid claims data for services occurring in the outpatient rural base period that were adjudicated by the Department through September 12, 2003.~~

~~e. Hospitals shall be notified in writing of the results of such eligibility determination and rate calculation for payments under this Section q. Hospitals shall have a right to appeal eligibility determinations and rate calculations if the hospital believes that a technical error has been made by the Department. The appeal must be submitted in writing to the Department and must be received or post marked within 30 days after the date of the Department's notice to the hospital qualification and payment calculation. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospitals appeal.~~

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05/13 30. Other Clinics

a. **Reimbursement for Freestanding Birth Centers**

Effective for dates of service on or after May 1, 2013:

i. Facility services provided by a birth center will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital for an uncomplicated vaginal birth.

ii. Observation services provided by a birth center will be reimbursed at the lower of billed charges or at 75 percent of the rate established by the Department for the number of hours of observation billed under one of three categories:

A. at least 60 minutes, but less than six hours and 31 minutes;

B. at least six hours and 31 minutes, but less than 12 hours; or

C. at least 12 hours and 31 minutes or more of observation services.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of birth center services. The agency's fee schedule rate was set as May 1, 2013 and is effective for services provided on or after that date. All rates are published on the agency's website.

iii. Transfer fees will be reimbursed to a birth center at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital for an uncomplicated vaginal birth.

Effective for dates of service on or after November 16, 2013:

i. Facility services provided by a birth center located in Cook County will be reimbursed at the lower of billed charges or 75 percent of the average facility payment made to a hospital located in Cook County for an uncomplicated vaginal birth.

ii. Facility services provided by a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 75 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.

iii. Observation services provided by a birth center will be reimbursed at the lower of billed charges or at 75 percent of the rate established by the Department for the number of hours of observation billed under one of three categories:

A. at least 60 minutes, but less than six hours and 31 minutes;

B. at least six hours and 31 minutes, but less than 12 hours; or

C. at least 12 hours and 31 minutes or more of observation services.

30. Other Clinics (continued)

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of birth center services. The agency's fee schedule rate was set as July 1, 2013 and is effective for services provided on or after that date. All rates are published on the agency's website.

iv. Transfer fees for a birth center located in Cook County will be reimbursed at the lower of billed charges or 15 percent of the average facility payment rate made to a hospital located in Cook County for an uncomplicated vaginal birth.

v. Transfer fees for a birth center located outside of Cook County will be reimbursed at the lower of billed charges or 15 percent of the statewide average facility payment rate made to a hospital located outside of Cook County for an uncomplicated vaginal birth.

b. Reimbursement for Freestanding End Stage Renal Disease Treatment

The amount approved for payment of esrdt shall be based on the methodology of 1.1.g of this attachment.

c. Reimbursement for Ambulatory Surgical Treatment Center

Ambulatory Surgical Treatment Center (ASTC) EAPG standardized amount. For ASTC's as defined in Attachment 3.1-A 21, the EAPG standardized amount is determined using the EAPG methodology described in Section 1.1, with the exception that simulated EAPG payments using ASTC base period paid claims data are equal to reported payments of ASTC base period paid claims data as contained in the Department's claims data warehouse.

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30. Other Clinics (continued)

d. Reimbursement for County-Operated Outpatient Facilities

i. County-operated outpatient facilities. A county-operated outpatient facility is a non- hospital-based clinic operated by and located in an Illinois county with a population exceeding three million.

A. Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility, that is within or adjacent to a large public hospital as defined in Chapter VII in Attachment 4.19-A

B. County ambulatory health centers. A county ambulatory health center is a County-operated outpatient facility that is not a critical clinic provider.

C. County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

ii. Methodology

A. For critical clinic providers~~, as described in Appendix to Attachment 3.1-A Section 140.461(h)(1),~~ reimbursement for all services, including pharmacy-only-encounters, provided shall be on an all-inclusive per day encounter rate that shall equal reported direct costs of Critic al Clinic Providers for each facility's cost reporting period ending in 1995, and available to the Department as of September 1, 1997, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.

B. For county ambulatory health centers, the final rate is determined as follows:

1. Base rate. The base rate shall be the rate calculated as follows:

a) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

b) The resulting quotient, as calculated in subsection (i) of this subsection (c)(2)(A), shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

c) The resulting product, as calculated in subsection (ii) of this Section, shall be added to the resulting quotient, as calculated in subsection (i) of this subsection (c)(2)(A), to determine the per encounter base rate.

d) The resulting sum, as calculated in subsection (iii) of this Section, shall be the base rate.

2. Supplemental rate.

a) The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

b) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

c) The quotient derived in subsection (i) of this subsection (c)(2)(B), shall be added to the product derived in subsection (ii) of this Section, to determine the per encounter supplemental rate.

d) The resulting sum, as described in subsection (iii) of this subsection (c)(2)(B), shall be the supplemental rate.

3. Final rate. The final rate shall be the sum of the base rate and the supplemental rate.

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07/08 **31. Hospital Outpatient Assistance Adjustment Payments**

a. Qualifying Criteria. Outpatient Assistance Adjustment Payments, as described in this subsection of this Section, with the exception of LARGE PUBLIC HOSPITAL, as defined in Chapter XXI of Attachment 4.19-A, shall be made to Illinois hospitals meeting one of the criteria identified below:

~~i. A hospital that qualifies for Disproportionate Share Adjustment payments for rate year 2007 as defined in Attachment 4.19-A, subchapter VI.C., has an EMERGENCY CARE PERCENTAGE greater than 70 percent and has provided greater than 10,500 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.~~

i.~~i~~. A GENERAL ACUTE CARE HOSPITAL that qualifies for Disproportionate Share Adjustment payments for rate year 2007 as defined in Attachment 4.19-A, subchapter VI.C, has an EMERGENCY CARE PERCENTAGE greater than 85 percent.

~~iii. A GENERAL ACUTE CARE HOSPITAL that does not qualify for Medicaid Percentage Adjustment payments for rate year 2007 as defined in Attachment 4.19-A, subsection VI.C.7.b., located in Cook county, outside the city of Chicago, that has an EMERGENCY CARE PERCENTAGE greater than 63 percent, that has provided more than 10,750 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year and has provided more than 325 Medicaid surgical group OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.~~

ii ~~iv~~.A GENERAL ACUTE CARE HOSPITAL located outside of Cook county, that qualifies for Medicaid Percentage Adjustment payments for rate year 2007 as defined in Attachment 4.19-A, subsection VI.G.1.d. ~~VI.C.7.b.~~, is a trauma center, recognized by the Illinois Department of Public Health as of July 1, 2006, that has an EMERGENCY CARE PERCENTAGE greater than 58 percent, and has provided more than 1,000 Medicaid non-emergency screening OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

iii ~~v~~.A hospital that has a MIUR of greater than 0.5000, an EMERGENCY CARE PERCENTAGE greater than 80 percent, and provided more than 6,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

iv ~~vi~~.A hospital that has a MIUR of greater than 0.7000 and an EMERGENCY CARE PERCENTAGE greater than 90.

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31. Hospital Outpatient Assistance Adjustment Payments continued

v ~~ii~~. A GENERAL ACUTE CARE HOSPITAL, not located in Cook County, that is a not trauma center, did not qualify for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Attachment 4.19-A, subsection VI.G.1.d. ~~VI.C.7.b~~., has a MIUR of greater than 25 percent, an EMERGENCY CARE PERCENTAGE greater than 50 percent, and provided more than 8,500 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

vi ~~iii~~. A GENERAL ACUTE CARE HOSPITAL, not located in Cook County, that is a level I trauma center, recognized by the Illinois Department of Public Health as of July 1, 2006, an EMERGENCY CARE PERCENTAGE greater than 50 percent, and provided more than 16,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, including more than 1,000 NON-EMERGENCY SCREENING OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, in the OUTPATIENT ASSISTANCE BASE YEAR.

vii ~~x~~. A GENERAL ACUTE CARE HOSPITAL, not located in Cook County, that qualified for Medicaid Percentage Adjustment payments for rate year 2007, as defined in Attachment 4.19-A, subsection VI.G.1.d. ~~VI.C.7.b~~., an EMERGENCY CARE PERCENTAGE greater than 55 percent, and provided more than 12,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, including more than 600 SURGICAL GROUP OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES and 7,000 reimbursed through methodologies described in subsection b.i.C of Chapter 1 of this attachment, in the OUTPATIENT ASSISTANCE BASE YEAR.

viii ~~x~~. A GENERAL ACUTE CARE HOSPITAL that has an EMERGENCY CARE PERCENTAGE greater than 75 percent, and provided more than 15,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

ix ~~xi~~. A rural hospital that has an has a MIUR of greater than 40 percent and provided more than 16,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES in the OUTPATIENT ASSISTANCE BASE YEAR.

x ~~ii~~. A GENERAL ACUTE CARE HOSPITAL, not located in Cook county, that is a trauma center, recognized by the Illinois Department of Public Health as of July 1, 2006, had more than 500 licensed bed in calendar year 2005, and provided more than 11,000 Medicaid OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, including more than 950 SURGICAL GROUP OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, in the OUTPATIENT ASSISTANCE BASE YEAR.

07/14 xi ~~xiv~~. A general acute care hospital is recognized as a Level I trauma center by DPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.

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31. Hospital Outpatient Assistance Adjustment Payments continued

b. Outpatient Assistance Adjustment Payments

Effective for outpatient hospital services on or after July 1, 2014, the following rates are in effect.

~~i. For hospitals qualifying under a.i., above the rate is $139.00~~

i ~~ii~~. For hospitals qualifying under a.i ~~ii~~., above the rate is $850.00~~.~~, for dates of service through February 28, 2014. For dates of service on or after March 1, 2014 through June 30, 2014, the rate is $1523.00. For dates of service on or after July 1, 2014, the rate is $0.00.

~~iii. For hospitals qualifying under a.iii., above the rate is $425.00.~~

07/14 ii ~~iv~~. For hospitals qualifying under a.ii~~v~~., above the rate is ~~$665.00~~ $290 for dates of service on or after July 1, 2014 through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00~~$375.00~~.

iii ~~v~~. For hospitals qualifying under a.iii ~~v~~., above the rate is $250.00

iv ~~vi~~. For hospitals qualifying under a.iv ~~vi~~., above the rate is $336.25

v ~~vii~~. For hospitals qualifying under a.v ~~vii~~., above the rate is $110.00

vi ~~viii~~. For hospitals qualifying under a.vi ~~viii~~., above the rate is $200.00

07/14 vii ~~ix~~. For hospitals qualifying under a.vii ~~ix~~., above the rate is $247.50 ~~$128.50for dates of through June 30, 2010. For dates of service on or after July 1, 2010 through June 30, 2012 December 31, 2014, this rate shall be increased by $74.00 to $202.50. For dates of service on or after January 1, 2015, the rate is $48.50. $0.00~~

07/14 viii ~~x~~. For hospitals qualifying under a.viii ~~x~~., above the rate is ~~$135.00~~ ~~for dates of service on or after July 1, 2010 through December 31, 2014 June 30,2012, this rate shall be increased by $70.00 to~~ $205 effective July 1, 2014. ~~For dates of service on or after January 1, 2015, the rate is $135.00~~

ix ~~xi~~. For hospitals qualifying under a.ix ~~xi~~., above the rate is $65.

x ~~xii~~. For hospitals qualifying under a.x ~~xii~~., above the rate is $90.00

07/14 xi. For hospitals qualifying under subsection a.xii, the rate is $47.00 for dates of service on or after July 1, 2010. ~~through December 31, 2014. For dates of service on or after January 1, 2015, the rate is $0.00.~~

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31. Hospital Outpatient Assistance Adjustment Payments continued

~~12/10/09~~ ~~xiii. A GENERAL ACUTE CARE HOSPITAL, located outside of Illinois, that provided more than 300 HIGH TECH DIAGNOSTIC MEDICAID OUTPATIENT AMBULATORY PROCEDURE LISTING SERVICES, in the outpatient assistance base year.~~

~~01/11~~ ~~xiv. A GENERAL ACUTE CARE HOSPITAL that is recognized as a Level I trauma center by IDPH on the first day of the OAAP rate period, has Emergency Level I services greater than 2,000, Emergency Level II services greater than 8,000, and greater than 19,000 Medicaid outpatient ambulatory procedure listing services in the outpatient assistance base year.~~

c. Payment to a Qualifying Hospital

The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by the Medicaid outpatient ambulatory procedure listing services in the OUTPATIENT ASSISTANCE ADJUSTMENT BASE YEAR. For the outpatient assistance adjustment period for fiscal year 2011 and after, total payments will equal the amount determined using the methodologies described in this subsection. The annual amount of each payment for which a hospital qualifies shall be paid, at least, quarterly.

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07/14~~07/08~~ 33. Payment to large public hospitals for ~~hospital~~ outpatient services.~~as defined in Chapter VII of Attachment 4.19-A government-owned or operated hospitals.~~

~~A. Definitions.~~

~~"BASE PERIOD" means the hospital fiscal year ending during the calendar year that is four years prior to the calendar year during which the payment period begins.~~

~~"PAYMENT PERIOD" means the State fiscal year.~~

~~B. Notwithstanding any other provision of this Attachment, reimbursement hospitals that are located in Illinois and are owned or operated by a county or a unit of local government shall be reimbursed for hospital outpatient services at allowable cost, as determined in section C of this chapter.~~

~~C. Hospitals reimbursed under this chapter shall be reimbursed at allowable cost to ensure that each class of hospitals is compliant with the upper payment limit requirement in 42 *CFR* 447.272. The rate paid for a service shall be the product of the rate established under subsection 1.b of this Attachment multiplied by a hospital-specific factor. The factor is the ratio of:~~

~~• BASE PERIOD costs – Determined as the product resulting from multiplying (i) the routine and ancillary charges on claims that were submitted by the hospital for Medicaid covered services provided during the BASE PERIOD and paid by the department by (ii) their respective cost-to-charge ratios from the BASE PERIOD cost report. The resulting product is adjusted to reflect the change, from the midpoint of the BASE PERIOD to the midpoint of the PAYMENT PERIOD, in the CMS hospital input price index.~~

~~to:~~

~~• Expected PAYMENT PERIOD reimbursement – Determined as the sum of the payments that would otherwise be made under subsection 1.b of this Attachment during the PAYMENT PERIOD for the services provided during the BASE PERIOD and paid by the department.~~

Large public hospitals, as defined in Chapter VII of Attachment 4.19-A, are included in the EAPG PPS for reimbursement for outpatient hospital services as described in Chapter 1.1 of this Attachment, and are to receive provider-specific EAPG standardized amounts.

a~~1~~. Outpatient EAPG Standardized Amount Calculation

Large public hospital outpatient EAPG standardized amounts are calculated as follows:

i~~a~~. Each Large public hospital's outpatient base year costs, including operating, capital and direct medical education costs, shall be calculated using outpatient base period claims data and Medicare cost report data with reporting periods matching the outpatient base period.

ii~~b~~. The outpatient base year costs shall be inflated from the midpoint of the outpatient base period claims data to the midpoint of the rate period based on an inflation methodology determined by the Department and approved by CMS.

iii~~c~~. EAPG standardized amounts shall be determined for each county-owned hospital such that simulated EAPG payments are equal to outpatient base period costs inflated to the rate period, based on outpatient based period paid claims data.

iv~~d~~. EAPG standardized amounts shall be reduced if resulting payments exceed available HFS funding or the Center for Medicare and Medicaid Services Upper Payment Limit.

b~~2~~. Rate Updates and Adjustments: Large public hospital EAPG standardized amounts shall be updated on an annual basis using more recent outpatient base period claims data, Medicare cost report data and costs inflation data.

c~~3~~. Definitions

"Outpatient base period paid claims data" means Medicaid fee-for-service outpatient paid claims data from the State fiscal year ending 24 months prior to the beginning of the rate period.

"Rate period" means the State fiscal year for which the county-owned hospital inpatient and outpatient rates are effective.

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[MATERIAL REMOVED]

~~04/09~~ ~~34. Catastrophic Relief Payments~~

~~a. Qualifying Criteria. Catastrophic Relief Payments, as described in this section, shall be made to Illinois hospitals, except publicly owned or operated hospitals or a hospital identified under subsection II.C.3.b of Attachment 4.19-A., that have an MIUR greater than the current statewide mean, are not a publicly owned hospital, and are not part of a multiple hospital network, unless the hospital has an MIUR greater than the current statewide mean plus two standard deviations. Payments to qualifying hospitals will be based on criteria described in this Section.~~

~~b. Payments.~~

~~i. An Illinois hospital qualifying under subsection 34.a of this Section that received payments under Section 32 will receive the greater of:~~

~~A. 2% of the annual Outpatient Ambulatory Procedure Listing Increase Payments, as defined in Section 32; or~~

~~B. $175,000.~~

~~ii. Payments under this Section are effective for State fiscal year 2009, and will be distributed prior to June 30, 2009. Payments are not effective for dates of service on or after July 1, 2009.~~

~~c. Definitions~~

~~i. "MIUR" means Medicaid inpatient utilization rate as defined in subsection VI.C.8.e of Attachment 4.19-A. For purposes of this Section, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2009 shall be the same determination used to determine a hospital's eligibility for Catastrophic Relief Payments in the Adjustment Period.~~

~~d. Rate reviews.~~

~~i. A hospital shall be notified in writing of the results of the payment determination pursuant to this Chapter.~~

~~ii. Hospitals shall have a right to appeal pursuant to the provisions of section C.2 of Chapter XXI of Attachment 4.19-A.~~

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[MATERIAL REMOVED]

~~12/10/09 35. Rural Emergency Services Stimulus Adjustment~~

~~a. Qualifying criteria. A rural Illinois HOSPITAL, as defined in subsection B.3.a. of Chapter XVI of Attachment 4.19-A, licensed by the Department of Public Health under the Hospital Licensing Act, certified by that Department to participate in the Illinois Medicaid Program, and enrolled with the Department of Healthcare and Family Services to participate in the Illinois Medicaid Program; that provides services in an emergency room.~~

~~b. Payment. A HOSPITAL meeting the qualifying criteria shall receive a one-time supplemental outpatient payment equal to:~~

~~i. The hospital's OUTPATIENT AMBULATORY PROCEDURE LISTING PAYMENTS for Group 3 services, as defined in Section 1.b.i.C., except that;~~

~~ii. A qualifying hospital designated as a critical access hospital, by the Illinois Department of Public Health in accordance with 42 CFR 485, Subpart F (2001) as of July 1, 2009, shall have the payment as determined in subsection (b)(i) multiplied by 3.5, rounded to the nearest whole dollar.~~

~~c. Adjustments and Limitations. All the provisions in Section E of Chapter XXXIII of Attachment 4.19-A will apply to the Rural Emergency Services Stimulus Adjustment detailed in this Chapter.~~

~~d. Definitions.~~

~~i. "HOSPITAL" means any facility located in Illinois that is required to submit cost reports as mandated in Section G of Chapter VIII of Attachment 4.19-A.~~

~~ii. "OUTPATIENT AMBULATORY PROCEDURE LISTING PAYMENTS" means, for a given hospital, the sum of payments for individuals covered under the Title XIX Medicaid State plan, for its ambulatory procedure listing Group 3 services as described in Section 1.b.i.C., excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring in the outpatient assistance base period that were adjudicated by the Department through March 23, 2007.~~

~~e. Rate Reviews.~~

~~i. A hospital shall be notified in writing of the results of the payment determination pursuant to this Chapter.~~

~~ii. Hospitals shall have a right to appeal pursuant to the provisions of Section C.2 of Chapter XXI of Attachment 4.19-A.~~

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07/14 46. Hospital Rate Reductions

For dates of service on or after July 1, 2012, outpatient reimbursement methodologies paid to hospitals as described in this attachment shall be reduced by 3.5%, for the rates that were otherwise in effect on July 1, 2012. For dates of service on and after July 1, 2014, the 3.5 percent rate reduction extends to Chapter 1.1 of this Attachment. Rate reductions defined in this chapter shall not apply to:

a ~~1~~. Rates or payments for hospital services delivered by a hospital defined as a safety net hospital under Section XV (K) (1) of Attachment 4.19-A.

b ~~2~~. Rates or payments for hospital services delivered by a hospital defined as a Critical Access Hospital that is an Illinois hospital designated by Illinois Department of Public Health in accordance with 42 CFR 485 Subpart F.

c ~~3~~. Rates or payments for hospital services delivered by a hospital that is operated by a unit of local government or state university that provides some or all of the non-federal share of such services.

d 4. Rates or payments for hospital outpatient services defined in Chapters 40 through 45 of this attachment.

1. INPATIENT HOSPITAL SERVICES (OTHER THAN THOSE PROVIDED IN AN INSTITUTION FOR MENTAL DISEASES OR TUBERCULOSIS)

- Certain inpatient hospital services are subject to review by the Department's Peer Review Organization and will not be covered unless medical necessity is shown and documented. At least thirty days prior to the effective date, hospitals are notified of changes to review requirements. Statewide hospital review requirements are specified in the Department's provider manuals and/or notices.
- Preoperative days will be limited to only the day immediately preceding surgery unless the attending physician provides documentation demonstrating the medical necessity of an additional day or days.
- Inpatient psychiatric services are subject to a review by the Department's Peer Review Organization. Only medically necessary inpatient psychiatric care will be approved.
- Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, which are medically necessary to correct or lessen health problems detected or suspected by the screening process, must be provided to individuals under 21 years of age.

07/12

- Services will not be covered for clients 21 years of age and older who present at a hospital for alcohol or drug–induced detoxification if that client was discharged from a hospital within 60 days for treatment of such services.

2. OUTPATIENT HOSPITAL SERVICES

Most outpatient hospital services provided are covered utilizing specific fee-for-service codes. Utilization control, *e.g.*, prior approval policies which may apply to the service in question and which would be required of non-hospital providers rendering services on a fee-for-service basis, is in effect.

07/02

The Enhanced Ambulatory Patient Groups (EAPGs) define those technical procedures that routinely require the use of the hospital outpatient setting, its technical staff and/or equipment. This list is updated annually.

Client coverage policies applicable to those services provided under the policy used by non-hospital providers include any requirements for utilization control or prior approval as specified in the *Illinois Administrative Code* and provider handbooks.

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AMOUNT, DURATION, AND SCOPE OF SERVICES

[Material Removed]

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State: **Illinois**

AMOUNT, DURATION, AND SCOPE OF SERVICES

[Material Removed]

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AMOUNT, DURATION, AND SCOPE OF SERVICES

[Material Removed]

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AMOUNT, DURATION, AND SCOPE OF SERVICES

[Material Removed]

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AMOUNT, DURATION, AND SCOPE OF SERVICES

[Material Removed]

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AMOUNT, DURATION, AND SCOPE OF SERVICES

[Material Removed]

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[Material Removed]

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[Material Removed]

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[Material Removed]

07/95 2c. In order for FQHCs to participate, they must meet one of the following:

a) Receive a grant under Section 329, 330 or 340 of the *Public Health Service Act*; or

b) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are determined to meet the requirements for receiving such a grant.

9. Clinic Services Continued

07/14 • ENCOUNTER RATE CLINICS

Encounter Rate Clinics are free-standing clinics which were enrolled in the Medicaid Program prior to July 1, 1998, that are reimbursed on an encounter rate basis as defined in Chapter 3 of Attachment 4.19-B. An Encounter Rate Clinic may also be a clinic operated by a county with a population of over three million that is reimbursed on an encounter rate basis as described in Chapter 3 of Attachment 4.19-B, but does not qualify as a Critical Clinic Provider as defined in Chapter 30 of Attachment 4.19-B or as a Non Hospital Based Clinic as described in Chapter 30 of Attachment 4.19-B.

07/14 • COUNTY-OPERATED OUTPATIENT FACILITIES

County-operated outpatient facilities. A county-operated outpatient facility is a non-hospital based clinic operated by and located in an Illinois county with a population exceeding three million and meeting the requirements of 42 CFR 440.90.

a. Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility, that is within or adjacent to a large public hospital defined as owned and located in an Illinois county with a population exceeding three million.

b. County ambulatory health centers. A county ambulatory health center is a County-operated outpatient facility that is not a critical clinic provider.

c. County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.