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State/Territory Name: Illinois

State Plan Amendment (SPA) #:18-0005

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

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

Financial Management Group

JUN 20 2018

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) 18-0005

Dear Ms. Norwood:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0005. Effective July 1, 2018, Illinois proposes new hospital payment methodologies that will be funded in part by a new assessment on hospital services.

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 18-0005 is approved effective July 1, 2018. 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	2. STATE:
18-0005	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, 2018

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 1902 of the *Social Security Act*

7. FEDERAL BUDGET IMPACT
a. FFY ~~18~~ ~~2019~~ - $55,800,000 FY18 OP. ($1,550,000) IP +$57,350,000
b. FFY ~~19~~ ~~2020~~ - $223,200,000 FY19 OP ($6,200,000) +$229,400,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Section 23 below.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable):*

Attachment 4.19-A: 1, 30.1, 30.3, 30.4, 30.5, 30.6, 30.7, 59.1, 61, 65.1, 69.1, 74C, 74E, 124, 125, 126A, 127, 128, 131A, 131B1, 131B2, 131C1, 131C2, 131E, 131M3, 131M7, 131M9, 131M12, 135, 137-140, 144-154, ~~155A~~, 161-167

Attachment 4.19-B: 13.1., 14.1, 16.1, 17.1, 21.1, ~~23.1~~, 23.1, 25.1A, 50-52A, 55, 60A-60H ces 6/14/18

10. SUBJECT OF AMENDMENT:
Changes to 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: **Felicia F. Norwood**

14. TITLE: **Director of Healthcare and Family Services**

15. DATE SUBMITTED: 30/30/2018 ces 6/14/18

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: JUN 20 2018

PLAN APPROVED--ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME Kristin Fan

22. TITLE: Director, FMC

23. REMARKS: 30.3A

4.19-A: 1, 30.1, 30.3, 30.4, 30.5, 30.6, 30.7, 59.1, 61, 65.1, 69.1, 74C, 74E, 124, 125, 126A, 127, 128, 131A, 131B1, 131B2, 131C1, 131C2, 131E, 131M3, 131M7, 131M9, 131M12, 135, 137-140, 144-154, ~~155A~~, 161-167, 172-188, 189

4.19-B: 13.1., 14.1, 16.1, 17.1, 21.1, ~~23.1~~, 25.1A, 50-52A, 55, 60A-60H, 65-71, 72

^ 23.1 25.1B
ces 6/14/18

JWD

FORM CMS-179 (07/92) *Instructions on Back*

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 A. Scope

1. Effective 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.

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.

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.

01/16 D-1. For non-Large Public Hospitals, 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.

07/18 D-2. Effective July 1, 2018 through June 30, 2020, for out-of-state, cost reporting hospitals, 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 out-of-state standardized amount and the GME factor.
   B. The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage, the out-of-state standardized amount and the GME factor.

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.
07/18	841	Extensive three degree burns with skin graft, as of July 1, 2018 through June 30, 2020.
07/18	842	Full thickness burns with graft, as of July 1, 2018 through June 30, 2020.
07/18	843	Extensive burns without skin graft, as of July 1, 2018 through June 30, 2020.
07/18	844	Partial thickness burns with or without graft, as of July 1, 2018 through June 30, 2020.
	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. 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:

07/18

      i. Hospital was recognized by the Department of Public Health as a level III perinatal center on the date of admission. Effective July 1, 2018 through June 30, 2020, hospital was recognized by the Department of Public Health as a level II, II+ or 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: 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.

07/18 5. Crossover Adjustment Factor effective July 1, 2018 through June 30, 2020

DRG standardized amounts, as defined in subsection J-1, shall be reduced by a Crossover Adjustment factor such that the absolute value of the total simulated payment reduction that occurs when applying the Crossover Adjustment factor to simulated DRG payments, including Policy Adjustments, using general acute hospital inpatient base period claims data, is equal to the difference of:

a. total simulated DRG payments using general acute hospital inpatient crossover claims data, and

b. general acute hospital inpatient crossover claims data total reported Medicaid net liability.

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.

01/16 I-1. For Large Public Hospitals as defined in Chapter VII, A and B, 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 grouper.
2. The DRG base rate determined such that simulated base period (as defined in Chapter XXX) DRG payments are equal to adjusted base period costs, as determined in subsection D.4 of Chapter XXX.

01/16 J-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 , 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 thereafter the beginning January 1, 2019, DRG grouper means the version 30 of the APR-DRG software.

07/18 Effective July 1, 2018 through June 30, 2020, "DRG grouper" means the DRG grouper version 33 of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems.

"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, 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 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.

07/18 Effective July 1, 2018 through June 30, 2020, "inpatient base period claims data" means State fiscal year 2015 inpatient Medicaid claims data allowed amounts, for DRG PPS payment for services provided in State fiscal years 2019 and 2020 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 more million less than the sum of inpatient based period paid claims data reported payments and allocated inpatient static payments.

07/18 Effective July 1, 2018 through June 30, 2020, "statewide standardized amount" means (1) all Illinois hospitals, and (2) out-of-state hospitals that are designated a level I pediatric trauma center or a level I trauma center by the Illinois Department of Public Health as of December 1, 2017, the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS allowed amounts, less the rate reductions defined in Chapter XL of this Attachment, results in approximately a $238.5 million increase inclusive of policy adjustors effective July 1, 2018 as defined in subsections (2) and (3) of this Section, compared to the sum of the inpatient based period claims data allowed amounts.

"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).

07/18 Effective July 1, 2018 through June 30, 2020, "out-of-State standardized amount" means for cost-reporting hospitals located outside of Illinois that are not included in the in-state standardized amount, the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS allowed amounts, without SMART Act reductions or GME factor adjustments, using general acute hospital inpatient based period claims data, are equal to the sum of inpatient based period claims data allowed amount.

07/18 Effective July 1, 2018 through June 30, 2020, "allowed amounts" means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for fiscal year 2015 MCO encounter data adjusted with a completion factor and fee-for-service claims data, excluding Medicare dual eligible claims.

	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.
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	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.

10/03

2. Calculation of Medicaid High Volume Adjustments

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

07/18

   b. For children's hospitals, as defined in Chapter VII, the payment adjustment calculated under Section F.2.a above shall be multiplied by 2.0.

   c. The amount calculated pursuant to Sections F.2.a and F.2.b. above shall be adjusted 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 Hartwell 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.

07/95

   d. 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.

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.

07/18 2. A unit within a general hospital that was enrolled with the Department as a children's hospital on July 1, 2013.

07/18 3. Effective July 1, 2018 through June 30, 2020, a unit within a general hospital has been designated as a (1) Perinatal Level III center by the Illinois Department of Public Health as of December 1, 2017, (2) is a Pediatric Critical Care Center designated by the State as of December 1, 2017, (3) and has a 2017 Medicaid inpatient utilization rate equal to or greater than 45% as of July 1, 2018.

07/18 4. Effective July 1, 2018 through June 30, 2020, a unit within a general hospital has been designated as a (1) Perinatal Level II center by the Illinois Department of Public Health as of December 1, 2017, (2) has a 2017 Medicaid Inpatient Utilization Rate greater than 70%, and (3) has at least 10 pediatric beds as listed on the Illinois Department of Public Health 2015 calendar year hospital profile as of July 1, 2018.

5. For hospitals identified in C.2 – C.4., 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. 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.

d. Distinct part rehabilitation unit. Payment for inpatient rehabilitation services provided by a distinct part rehabilitation unit, as defined in Chapter VII:

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.

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. of this Chapter, and

b) 80% of 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.

07/18 iii Effective July, 1, 2018 through June 30, 2020, plus $96.00.

4. Reimbursement Methodologies for Children's Specialty Hospitals

   a. Inpatient general acute care services provided by a Children's Specialty Hospital located in Illinois as defined in Chapter II.C.3. and with fewer than 50 total inpatient beds and excluded from the DRG PPS shall per day of covered inpatient care be reimbursed as follows:

      i. For a hospital that would not have met the definition of a children's specialty hospital as of July 1, 2013, $1,400.00 per day.

      ii. For a hospital that would have met the definition of a children's specialty hospital as of July 1, 2013, a rate equal to the per diem base rate in place on July 1, 2013, multiplied by a factor of 1.37.

      iii. The total payment for inpatient stay will equal the sum of:

         A) The payment determined in this Section; and

         B) Any applicable adjustments to payment specified in Chapters VI, VIII, XV and XL.

07/18

   b. Effective July 1, 2018 through June 30, 2020, rates in subsection 4.a. above are increased by 10.5 percent.

   c. Access to Care

      i. To ensure access to care and maintain stability for children's specialty hospitals located in Illinois, the Department shall make annual transitional payments equal to the product of:

         A) The amount of static payments made to the hospital in State fiscal year 2011, excluding those payments that continue after July 1, 2014 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; and

         B) .8695.

      ii. The annual amount determined in this Section shall be paid in monthly installments equal to 1/12 of the annual amount.

   d. For cost reporting hospitals located outside of Illinois that meet the definition of a Children's specialty hospitals as defined in Chapter VII as of June 30, 2014, for inpatient general acute care and rehabilitation services, the hospital shall have a per diem amount equal to the rate in place with the Department as of June 30, 2014. The total payment for inpatient stay will equal the sum of the payment determined in this Subsection and any applicable adjustments to payments specified in Chapters VI, VIII, XV and XL.

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, 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.

07/18 g. Effective July 1, 2018 through June 30, 2020, rates in this subsection are increased by 10.5 percent.

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, 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, 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.

07/18 c. Effective on or after July 1, 2014 through June 30, 2018, 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.

07/18

e. Effective on or after July 1, 2014 through June 30, 2018, 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., 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

07/18

1. Reserved.

07/18 3. Reserved.

07/18 4. Reserved.

07/14 5. Hospitals qualifying under subsection C.1.b. 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.

07/18 6. Effective on or after July 1, 2014 through June 30, 2018, hospitals qualifying under subsection C.1.c. 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

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.

07/18 8. Reserved.

07/14 12. DHA Payments

a. Payments under this subsection D will be made at least quarterly.

b. Payment rates will be multiplied by the Total days.

07/18 c. The product of subsection 12.b. will be multiplied by the applicable tiering of subsection O.4. of this Chapter.

07/14 E. Reserved.

07/14 F. Reserved.

K. Safety Net Hospital Adjustment Payments

07/14

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:

07/18

a. Effective on or after July 1, 2014 through June 30, 2018, it has, as provided in subsection K., a MIUR equal to or greater than the 40%.

07/18

b. Effective on or after July 1, 2014 through June 30, 2018, it is, as of October 1, 2001, a rural hospital, as described in Chapter XVI, Section B.3, that meets 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.

07/18

c. Effective on or after July 1, 2014 through June 30, 2018, 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.

07/18

h. Effective on or after July 1, 2014 through June 30, 2018, 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) 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.

07/18

i. Effective on or after July 1, 2014 through June 30, 2018, 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.h. of this Section.

ii. Located outside Health Service Area (HSA) 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.

j. 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

k. 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) 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. 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. 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.

07/18 2. Reserved.

07/18 3. Reserved

07/18 4. Reserved.

07/18 5. For a hospital qualifying under subsection 1.d. of this Section, the rate is $140.00. Effective July 1, 2018, the rate is $105.00

6. For a hospital qualifying under subsection 1.e. of this Section, the rate is $119.50.

7. For a hospital qualifying under subsection 1.f. of this Section, the rate is $25.00.

8. For a hospital qualifying under subsection 1.g. of this Section, the rate is $221.00.

07/18 9. Reserved.

07/18 10. Reserved.

07/18 11. For a hospital qualifying under subsection 1.j. of this Section, the rate is $56.00. Effective July 1, 2018, the rate is $40.00.

12. For a hospital qualifying under subsection 1.k. of this Section, the rate is $197.00.

13. For a hospital qualifying under subsection 1.l. of this Section, the rate is $71.00.

4. Payment to a Qualifying Hospital
   a. The total annual payments to a qualifying hospital shall be the product of the hospital's rate multiplied by two multiplied by total days.

07/08

   b. Total payments will equal the sum of amounts calculated under the methodologies described in this subchapter K and shall be paid to the hospital during the safety net adjustment period in installments on, at least, a quarterly basis.
   c. For the rate period occurring January 1, 2011 to June 30, 2011, payments will equal the hospital's rate multiplied by two multiplied by Total days, less the amount the hospital received for the quarters ending September 30, 2010 and December 31, 2010.

07/18

   d. The product of subsection 4.a. will be multiplied by the applicable tiering of subsection O.4. of this Chapter.

5. Definitions
   a. "Average length of stay" means, for a given hospital, a fraction, in which the numerator is the number of total days and the denominator is the number of total admissions.
   b. "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR), plus the Medicaid obstetrical inpatient utilization rate, determined as of October 1, 2001, both of which are defined in Chapter VI.C.8.

07/06

   c. "Comprehensive emergency treatment services" means hospital emergency services with;
      i. at least one licensed physician shall be in the emergency department at all times;
      ii. physician specialist representing the major specialties, and sub-specialties such as plastic surgery, dermatology, ophthalmology, etc., shall be available within minutes, and
      iii. ancillary services including laboratory and x-ray shall be staffed at all times. Pharmacy shall be staffed or "on call" at all times.
   d. "General care admissions" means, for a given hospital, the number of hospital inpatient admissions for recipients of medical assistance under Title XIX of the Social Security Act, as tabulated from the Department's claims data for admissions occurring in the safety net hospital base year that were adjudicated by the Department by June 30, 2001, excluding admissions for: obstetrical care, as defined in paragraph (g); for normal newborns; for psychiatric care; for physical rehabilitation; and, those covered in whole or in part by Medicare (Medicaid/Medicare crossover admissions)
   e. "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.
   f. "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."

07/18 N. **Perinatal and rural care access payment effective July 1, 2018 through June 30, 2020.**

1. Qualifying Criteria. An Illinois non-publically owned general acute care hospital that is classified as a Perinatal Level II or II+ Center may qualify for this payment in one of the following ways:

   a. The hospital has 100 or less days, and total admits are 1,250 or less and has an occupancy ratio equal to or greater than 35%; or

   b. Is a rural hospital that has an MIUR of at least 33% or greater in rate year 2017 with an occupancy ratio equal to or greater than 60%.

2. Payment. A qualifying hospital shall receive a payment this is the product of the following factors:

   a. $10,000,000

   b. A quotient of:

      i. the numerator of which is the qualifying hospital's State fiscal year 2015 total admissions; and

      ii. the denominator of which is all State fiscal year 2015 total admissions for qualifying hospitals.

3. Definitions

   a. "Occupancy Ratio" is determined utilizing the IDPH Hospital Profile CY15 – Facility Utilization Data – Source 2015 Annual Hospital Questionnaire. Utilizes all beds and days including observation days but excludes Long Term Care and Swing bed and their associated beds and days.

   b. "Beds" is determined utilizing the IDPH Hospital Profile CY15 – Facility Utilization Data – Source 2015 Annual Hospital Questionnaire. Utilizes all beds and days but excludes Long Term Care beds and Swing bed.

   c. "Large Urban Hospital" refers to hospitals located in Metropolitan Statistical Areas with greater than one million people and includes the following counties: Bond, Calhoun, Clinton, Cook, DeKalb, DuPage, Grundy, Jersey, Kane, Kendall, Lake, Macoupin, Madison, McHenry, Monroe, Saint Clair, and Will.

   d. "Perinatal Level II or II+" means a center as defined by the Illinois Department of Public Health as of December 1, 2017.

   e. "Other Urban Hospital" refers to hospitals located in Metropolitan Statistical Areas Boone, Champaign, Ford, Henry, Kankakee, Macon, Marshall, McLean, Menard, Mercer, Peoria, Piatt, Rock Island, Sangamon, Stark, Tazewell, Vermillion, Winnebago, and Woodford.

   f. "Rural Hospital" refers to hospitals not located in a Metropolitan Statistical Area.

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 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. University-owned large public hospitals, county-owned large public hospitals, children's specialty hospitals and non-cost reporting hospitals.

      ii. Providers with a simulated payment gain under the new inpatient and outpatient systems combined.

07/18 iii. Out-of-state hospitals effective July 1, 2018 through June 30, 2020.

   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.

3. Timing.

   The Department shall make Transitional Supplemental Payments for the first four years of the new inpatient and outpatient payments systems effective during SFY 2015 through 2018.

07/18

4. Effective July 1, 2018 through June 30, 2020, a portion of the Transitional Payments shall be known as Transformation Payments.

   a. Tier 1: A hospital with a rate year 2017 MIUR equal to or greater than 45% the payment shall be equal to 100% of payments outlined in subsection 1.b of this Section.

   b. Tier 2: A hospital with a rate year 2017 MIUR equal to or greater than 25% but less than 45% the payment shall be equal to 75% of payments outlined in subsection 1.b. of this Section.

   c. Tier 3: A hospital with a rate year 2017 MIUR less than 25% the payment shall be equal to 50% outlined in subsection 1.b. of this Section.

07/18 Q. Effective on or after July 1, 2014 through June 30, 2018, 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 attachment, 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.

07/18

XVII. Graduate Medical Education (GME) Payment.

A. Definitions:

1. Medicare cost report ending in 2015, as reported in Medicare cost reports released on October, 19, 2016, with data through September 30, 2016.
2. "Hospital's annualized Medicaid Intern Resident Cost" is the product of the following factors:
   a. Annualized intern and resident costs obtained from Worksheet B Part I, Column 21 and 22 the sum of lines 30-43, 50-76, 90-93,96-98, and 105-112
   b. A quotient of:
      i. the numerator of which is the hospital's Medicaid days (Worksheet S3 Part I, Column 7, Lines 14 and 16-18), and
      ii. the denominator of which is the hospital's total days (Worksheet S3 Part I, Column 8, Lines 14 and 16-18).
3. "Hospital annualized Medicaid IME payment is the product of the following factors:
   a. Hospital IME payments (Worksheet E Part A, Line 29, Col1).
   b. A quotient of:
      i. the numerator of which is the hospital Medicaid days (Worksheet S3 Part I, Column 7, Lines 14 and 16-18), and
      ii. the denominator of which is the hospital Medicare days (Worksheet S3 Part I, Column 6, Lines 14 and 16-18).

B. Qualifying Criteria: An Illinois hospital, excluding large public hospitals, reporting intern and resident cost on its Medicare cost report ending in 2015 shall be eligible for a graduate medical education payment.

C. Payment. A qualifying hospital shall receive a payment that is the product of the following factors:

1. The sum of each hospital's annualized Medicaid Intern Resident Cost and annualized Medicaid IME payment.
2. 33 percent

07/18 **XVIII. Reserved.**

[MATERIAL REMOVED]

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]

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]

07/18 **XXI. Reserved.**

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]

[MATERIAL REMOVED]

07/18 **XXII. Reserved.**

07/18 **XXIII. Reserved.**

07/18 **XXIV. Reserved.**

07/18 **XXV. Reserved.**

07/18 **XXVI. Reserved.**

07/18 **XXVII. Reserved.**

07/18 **XXVIII. Reserved.**

07/18 **XXIX. Reserved.**

07/18 **XXIV. Reserved.**

[MATERIAL REMOVED]

07/18 **XXXV. Reserved.**

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)

07/18 **XXXVI. Reserved.**

07/18 **XXXVII. Reserved.**

07/18 **XXXVIII. Reserved.**

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)

07/18 **XXXIX. Reserved.**

07/18 **XLV. General Provisions effective July 1, 2018 through June 30, 2020.**

Unless otherwise indicated, the following apply to Chapters XLVI through LV.

A. Payments.

1. Effective July 1, 2018, payments shall be paid in 12 installments on or before the 7th State business day of the month.

2. The Department may adjust payments made under these Chapters to comply with federal law or regulations regarding disproportionate share, hospital-specific payment limitations on government-owned or government-operated hospitals as described in Chapter VII.g.7.iv.D. of this Attachment.

3. If the state or federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under these Chapters is exceeded, then the payments under these Chapters that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

B. Definitions. As used in this Section, unless the context requires otherwise:

1. "General acute care admissions" means, for a given hospital, the sum of inpatient hospital admissions provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, excluding admissions for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's paid claims data for general acute care admissions occurring during State fiscal year 2015 as of October 28, 2016.

2. "Occupancy ratio" is determined utilizing the Illinois Department of Public Heath Hospital Profile CY15 – Facility Utilization Data – Source 2015 Annual Hospital Questionnaire. Utilizes all beds and days including observation days but excludes Long Term Care and Swing bed and their associated beds and days.

3. "Outpatient services" means, for a given hospital, the sum of the number of outpatient encounters identified as unique services provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding outpatient services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for outpatient services occurring during State fiscal year 2015 as of October 28, 2016.

4. "Total days" means, for a given hospital, the sum of inpatient hospital days provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding days for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for total days occurring during State fiscal year 2015 as of October 28, 2016.

5. "Total admissions" means, for a given hospital, the sum of inpatient hospital admissions provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding admissions for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover admissions), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2015 as of October 28, 2016.

B. Definitions. As used in this Section, unless the context requires otherwise (continued):

6. Academic medical centers and major teaching hospital.

a. Hospitals dedicated to medical research and medical education shall be classified each State fiscal year in 3 tiers based on specific criteria:

i. Tier I. A private academic medical center must:

(A) be a hospital located in Illinois which is either:

(1) under common ownership with the college of medicine of a non-public college or university;

(2) 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

(3) a children's hospital which is separately incorporated and non-integrated into the academic medical center hospital but which 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 30graduate medical education programs accredited by Accreditation Council for Graduate Medical Education;

(C) facilitate the training on its 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;

(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 either directly or, with respect to hospitals described in item (ii) of subparagraph (A) of this paragraph, 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 in paragraph (4) of subsection (h) of Section 3-8 of the Service Use Tax Act no less than $5,000,000 toward medical research and education during the calendar year preceding the beginning of the State fiscal year.

B. Definitions. As used in this Section, unless the context requires otherwise (continued):

ii. Tier II. A public academic medical center must:

(A) be a hospital located in Illinois which is a primary teaching hospital affiliated with;

(1) University of Illinois School of Medicine at Chicago; or

(2) University of Illinois School of Medicine at Peoria; or

(3) University of Illinois School of Medicine at Rockford; or

(4) University of Illinois School of Medicine at Urbana; or

(5) 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.

iii. 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.

7. "MIUR" means Medicaid Inpatient Utilization Rate as defined in C.8.d of Chapter VI for rate year 2017.

8. "Publically owned hospital" means any hospital owned by a political subdivision

9. As used in this subsection, "service credit factor" is determined based on a hospital's Rate Year 2017 Medicaid inpatient utilization rate ("MIUR") rounded to the nearest whole percentage.

C. Rate reviews.

1. A hospital shall be notified in writing of the results of the payment determination pursuant to these Sections.

2. Hospitals shall have a right to appeal the calculation of, or their ineligibility for, payment if the hospital believes that the Department has made a technical error. The appeal must be submitted in writing to the Department and must be received or postmarked within 30 days after the date of the Department's notice to the hospital of its qualification for the payment amounts, or a letter of notification that the hospital does not qualify for 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.

07/18 **XLVI. Alzheimer's Treatment Access Payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria. An Illinois academic medical center or teaching hospital as defined in Section C.6. of Chapter XLV that is identified as the primary hospital affiliate of one of the regional Alzheimer's Disease Assistance Centers as designated by the Alzheimer's Disease Assistance Act and identified in the Illinois Department of Public Health Alzheimer's Disease State Plan dated December 2016.

B. Payment. A qualifying hospital shall receive a payment that is the product of the following factors:

1. $10,000,000
2. A quotient of:
   a. the numerator of which is the qualifying hospital's Fiscal Year 2015 total admissions; and
   b. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible for the payment.

07/18 **XLVII. Medicaid dependent hospital access payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria. To qualify for a Medicaid dependent hospital access payment, a hospital shall meet one of the following criteria:

1. Be a non-publicly owned general acute care hospital that is a safety-net hospital, as defined in subsection F-1.4.b. of Chapter IV of this Attachment, for Rate Year 2017.
2. Be a pediatric hospital that is a safety net hospital, as defined in subsection F-1.4.b. of Chapter IV of this Attachment, for Rate Year 2017 and have a Medicaid inpatient utilization rate equal to or greater than 50%.
3. Be a general acute care hospital with a Medicaid inpatient utilization rate equal to or greater than 50% in Rate Year 2017.

B. Definitions:

1. A Tier 1 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean but less than the statewide mean plus 0.5 standard deviation.
2. A Tier 2 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus 0.5 standard deviations but less than the statewide mean plus one standard deviation.
3. A Tier 3 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus one standard deviation but less than the statewide mean plus 1.5 standard deviations.
4. A Tier 4 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus 1.5 standard deviations but less than the statewide mean plus 2 standard deviations.
5. A Tier 5 Medicaid dependent hospital means a qualifying hospital with a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than the statewide mean plus 2 standard deviations.

Medicaid dependent hospital access payment effective July 1, 2018 through June 30, 2020 (continued)

C. Payment: Medicaid dependent hospital access payments shall be determined as follows:

1. Each Tier 1 hospital shall be paid a Medicaid dependent hospital access payment equal to the product of:
   a. $23,000,000
   b. A quotient of:
      i. the numerator of which is the hospital's Fiscal Year 2015 total days; and
      ii. the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment.
2. Each Tier 2 hospital shall be paid a Medicaid dependent hospital access payment equal to the product of:
   a. $15,000,000
   b. A quotient of:
      1. the numerator of which is the hospital's Fiscal Year 2015 total days; and
      2. the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment.
3. Each Tier 3 hospital shall be paid a Medicaid dependent hospital access payment equal to the product of:
   a. $15,000,000
   b. A quotient of:
      1. the numerator of which is the hospital's Fiscal Year 2015 total days; and
      2. the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment.

Medicaid dependent hospital access payment effective July 1, 2018 through June 30, 2020 (continued)

4. Each Tier 4 hospital shall be paid a Medicaid dependent hospital access payment equal to the product of:
   a. $53,000,000
   b. A quotient of:
   1. the numerator of which is the hospital's Fiscal Year 2015 total days; and
   2. the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment.
5. Each Tier 5 hospital shall be paid a Medicaid dependent hospital access payment equal to the product of:
   a. $75,000,000
   b. A quotient of:
      1. the numerator of which is the hospital's Fiscal Year 2015 total days; and
      2. the denominator of which is the Fiscal Year 2015 total days for all hospitals eligible under this subparagraph for this payment.

07/18 **XLVIII. Medicaid high volume access payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: To qualify for a Medicaid high volume hospital access payment, a hospital shall meet all of the following criteria:

1. Does not qualify as a Medicaid dependent hospital, per section A. of Chapter XLVII.
2. Is an Illinois general acute care hospital with the highest number of Fiscal Year 2015 total admissions that when ranked in descending order from the highest Fiscal Year 2015 total admissions to the lowest Fiscal Year 2015 total admissions, in the aggregate, sum to at least 50% of the total admissions for all such hospitals in Fiscal Year 2015.

B. Payments: Each qualifying hospital shall be paid a Medicaid dependent hospital access payment equal to the product of:

1. $300,000,000
2. A quotient of:
   a. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and
   b. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this subparagraph for this payment.

07/18 **XLIX. Perinatal care access payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: To qualify for a perinatal care access payment, a hospital shall meet one of the following criteria:

1. Illinois non-publicly owned hospital designated a Level II or II+ perinatal center by the Illinois Department of Public Health as of December 1, 2017.
2. Illinois non-publicly owned hospital designated a Level III perinatal center by the Illinois Department of Public Health as of December 1, 2017.

B. Payment: Perinatal care access payments shall be determined as follows:

1. Each hospital qualifying under subsection A.1. of this section, shall be paid a perinatal care access payment equal to the product of:
   a. $200,000,000
   b. A quotient of:
      i. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and
      ii. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.
2. Each hospital qualifying under subsection A.2. of this section, shall be paid a perinatal care access payment equal to the product of:
   a. $100,000,000
   b. A quotient of:
      i. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and
      ii. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

07/18 **L. Long-term acute care access payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: To qualify for a Long-Term Acute Care Access Payment, a hospital shall meet all of the following criteria:

1. An Illinois
2. Non-publicly owned
3. Long-term acute care hospital
4. Has a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than 25%
5. Has a calendar year 2015 occupancy ratio equal to or greater than 60%

B. Payment: Each qualifying hospital shall be paid a Long-Term Acute Care Access Payment equal to the product of:

1. $19,000,000
2. A quotient of:
   a. the numerator of which is the hospital's Fiscal Year 2015 general acute care admissions; and
   b. the denominator of which is the Fiscal Year 2015 general acute care admissions for all hospitals eligible under this subsection for this payment.

07/18 **LI. Small public hospital access payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: As used in this subsection, "small public hospital" means any Illinois publicly owned hospital which is not a "large public hospital" as defined in Chapter VII. of this Attachment.

B. Payment: Each small public hospital shall be paid an inpatient access payment equal to the product of:

1. $2,825,000
2. A quotient of:
   a. the numerator of which is the hospital's Fiscal Year 2015 total days; and
   b. the denominator of which is the Fiscal Year 2015 total days for all hospitals under this paragraph for this payment.

07/18 **LII. Perinatal and Trauma Center Access Payment effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: To qualify for a Perinatal and Trauma care access payment, a hospital shall meet one of the following criteria:

1. Illinois non-publicly owned hospital designated a Level III perinatal center and a Level I or II trauma center by the Illinois Department of Public Health as of December 1, 2017, and that has a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than 20% and a calendar year 2015 occupancy ratio equal to or greater than 50%,

2. Illinois non-publicly owned hospital designated a Level II or II+ perinatal center and a Level I or II trauma center by the Illinois Department of Public Health as of December 1, 2017, and that has a Rate Year 2017 Medicaid inpatient utilization rate equal to or greater than 20% and a calendar year 2015 occupancy ratio equal to or greater than 50%.

B. Payment: Perinatal and Trauma care access payments shall be determined as follows:

1. Each hospital qualifying under subsection A.1. of this section, shall be paid a Perinatal and Trauma care access payment equal to the product of:

   a. $160,000,000

   b. A quotient of:

      i. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and

      ii. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

2. Each hospital qualifying under subsection A.2. of this section, shall be paid a Perinatal and Trauma care access payment equal to the product of:

   a. $200,000,000

   b. A quotient of:

      i. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and

      ii. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

07/18 **LIII. Simulated Base Rate Adjustment effective July 1, 2018 through June 30, 2020.**

A. Qualifying criteria. Non-publically owned hospitals qualifying for this payment include:

1. General acute care hospitals located in Illinois
2. Psychiatric hospital located in Illinois
3. Rehabilitation hospitals located in Illinois
4. Children's hospitals located in Illinois
5. Children's hospitals located in St. Louis that are designated a Level III perinatal center by the Illinois Department of Public Health and also designated a Level I pediatric trauma center by the Illinois Department of Public Health as of December 1, 2017.

B. Definitions

1. Tier 1: A hospital with a MIUR equal to or greater than 60% shall have a service credit factor of 200%.
2. Tier 2: A hospital with a MIUR equal to or greater than 33% but less than 60% shall have a service credit factor of 100%.
3. Tier 3: A hospital with a MIUR equal to or greater than 20% but less than 33% shall have a service credit factor of 50%.
4. Tier 4: A hospital with a MIUR less than 20% shall have a service credit factor of 10%.
5. Inpatient general acute care pool amount is equal to $268,051,572
6. Inpatient Rehabilitation Care Pool amount is equal to $24,500,610.
7. IP Psych Care Pool amount is equal to $94,617,812.

C. Payment. Each Illinois hospital and other hospitals authorized under this subsection shall be assigned a pool allocation percentage for each category of service that is equal to the ratio of:

1. the hospital's estimated FY 2019 claims-based payments including all applicable FY 2019 policy adjusters,
2. multiplied by the applicable service credit factor for the hospital,
3. divided by the total of the FY 2019 claims-based payments including all FY 2019 policy adjusters for each category of service adjusted by each hospital's applicable service credit factor for all qualified hospitals.
4. For each category of service, a hospital shall receive a supplemental payment equal to its pool allocation percentage multiplied by the total pool amount.

07/18 **LIV. Psychiatric care access payment for freestanding psychiatric hospitals effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: Illinois freestanding psychiatric hospitals, as defined in Chapter VIII.

B. Payment: Final payment shall be the greater of :

1. The product of:
   a. Modeled payment increase and
   b. 90 percent and
   c. 75 percent
2. Zero

C. Definitions:

1. DRG Weight Per Day = (DRG Weight) / (DRG Average Length of Stay)
2. Wage Index Adjustment = (Medicare IPPS Labor Share Percentage) x (Medicare IPPS Wage Index) + [1 - (Medicare IPPS Labor Share Percentage)]
3. Acuity- and Wage Index-Adjusted Days = (Covered Days) x (DRG Weight Per Day) x (Wage Index Adjustment)
4. DRG Per Diem Rate = (Enhanced Funding Pool) / (SUM of Acuity- and Wage Index-Adjusted Days)
5. "Modeled allowed amount" shall be the product of:
   a. Covered Days and
   b. DRG Weight Per Day and
   c. Wage index Adjustment and
   d. DRG Per Diem Rate
6. "Modeled payment increase" shall be the difference in:
   a. Modeled allowed amount and
   b. Actual allowed amount.
7. "Actual allowed amount" means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for fiscal year 2015 psychiatric MCO encounter data adjusted with a completion factor and fee-for-service claims data, excluding Medicare dual eligible claims.

8. "DRG weight" 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 Version 30 DRG grouper, and the Illinois experience adjustment.

9. "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 Version 30 DRG grouper.

10. "Medicare IPPS wage index" means:

    a. For hospitals identified as inpatient psychiatric in the quarterly CMS provider-specific files, the wage index is based on the Medicare Final Rule inpatient psychiatric facility prospective payment system (IPF PPS) post-reclass wage index effective October 1, 2016.

    b. For hospitals not identified as inpatient psychiatric in the quarterly CMS provider-specific files and that are in-state or are out-of-state Medicaid cost reporting hospitals, the wage index is based on the Medicare Proposed Rule inpatient prospective payment system (IPPS) post-reclass wage index effective October 1, 2017.

    c. For hospitals not identified as inpatient psychiatric in the quarterly CMS provider-specific files and that are in-state non-Medicare IPPS hospitals and out-of-state non-Medicaid cost reporting hospitals, the wage index is based on the Medicare Proposed Rule inpatient prospective payment system wage index for the hospital's Medicare CBSA effective October 1, 2017.

11. "Medicare labor share percentage" means:

    a. For hospitals identified as inpatient psychiatric in the quarterly CMS provider-specific files, the labor share percentage is the Medicare Final Rule inpatient psychiatric facility prospective payment system (IPF PPS) labor share percentage effective October 1, 2016, which is 0.7510.

    b. For hospitals not identified as inpatient psychiatric in the quarterly CMS provider-specific files, the labor share percentage is the Medicare Proposed Rule inpatient prospective payment system (IPPS) labor share percentage effective October 1, 2017, which is 0.6830 for hospitals with a Medicare IPPS wage index greater than 1.0 and 0.6200 for all other hospitals.

12. "Enhanced Funding Pool" means $105,927,553.

07/18 **LV. Psychiatric care access payment for distinct part units effective July 1, 2018 through June 30, 2020.**

A. Qualifying Criteria: In-state cost reporting acute care hospitals with a psychiatric distinct part unit, as defined in Chapter VII.

B. Payment: The annual payment amount shall be the greater of:

1. Zero, or
2. The difference of:
   a. The product of:
      i. Modeled payment increase and
      ii. 90 percent and
      iii. 75 percent
   b. the inpatient base period claims data allowed amount.

C. Definitions:

1. "DRG modeled payments" means the lesser of charges, or the product, rounded to the nearest hundredth, of:
   a. The DRG weighting factor of the DRG and SOI, to which the inpatient stay was assigned by the DRG grouper.
   b. The DRG base rate, equal to the sum of:
      i. The product, rounded to the nearest hundredth, of the Medicare IPPS labor share percentage, Medicare IPPS wage index and the psychiatric standardized amount.
      ii. The product, rounded to the nearest hundredth, of the Medicare IPPS non-labor share percentage and the psychiatric standardized amount.
2. "Psychiatric standardized amount" means the average amount as the basis for the DRG base rate established by the Department such that simulated DRG PPS allowed amount, without SMART Act reductions or GME factor adjustments, using psychiatric hospital inpatient based period paid claims data, are $59,637,125 more than the sum of psychiatric inpatient based period paid claims data allowed amounts.
3. "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.
4. "Medicare IPPS non-labor share" means the difference of 1.0 and the Medicare IPPS labor share percentage.

Psychiatric care access payment for distinct part units (continued)

5. "DRG" means diagnosis related group, as defined in the DRG grouper, based the principal diagnosis, surgical procedure used, age of patient, etc.
6. "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.
7. "Inpatient base period claims data" means State fiscal year 2015 inpatient psychiatric Medicaid fee-for-service and statistically completed MCO encounter claims data, excluding Medicare dual eligible claims.
8. "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.
9. "Illinois experience adjustment" means a quotient, computed by dividing the constant 1.0000 by the arithmetic mean 3M APR-DRG national weighting factors of claims for inpatient stays using inpatient base period claims data, rounded to the nearest ten-thousandth.
10. "DRG grouper" means the version 33 of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, distributed by 3M Health Information Systems.
11. "Modeled payment increase" shall be the difference in:
    a. DRG modeled payments and
    b. Actual allowed amount.
12. "Actual allowed amount" means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for fiscal year 2015 psychiatric MCO encounter data adjusted with a completion factor and fee-for-service claims data, excluding Medicare dual eligible claims.

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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. of Attachment 4.19-A, Page 65.1, 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. of Attachment 4.19-A, Page 65.1, the EAPG standardized amount is determined in Chapter 33of 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.

07/18 C. Effective July 1, 2018 through June 30, 2020, simulated EAPG payments using outpatient base period paid claim data plus payments as defined in Chapter 49 of this Attachment, net of tax costs equal to estimated costs as described in subsection d.iii.B. of this Section.

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.

07/18 3. Effective July 1, 2018 through June 30, 2020, in-state hospital simulated EAPG payment using general acute hospital outpatient base period claims data, less the rate reductions defined in Chapter 46 of this Attachment and less the increase in payment from d.3.C. above, results in a $238 million increase inclusive of add-on payments as defined in subsection k. of this Section, compared to the sum of the acute hospital outpatient based period claims allowed amount.

07/14 1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

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 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.

07/18 3. Effective July 1, 2018 through June 30, 2020, in-state hospital simulated EAPG payment using freestanding psychiatric hospitals and psychiatric distinct part units outpatient base period claims data less the rate reductions defined in Chapter 46 of this Attachment results in a $3,870,000 increase compared to the sum of psychiatric hospital outpatient based period claims allowed amount.

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.

07/18 3. Effective July 1, 2018 through June 30, 2020, in-state hospital simulated EAPG payment using freestanding rehabilitation hospitals and rehabilitation distinct part units outpatient base period claims data less the rate reductions defined in Chapter 46 of this Attachment results in a $57,400 increase compared to the sum of rehabilitation hospital outpatient based period claims allowed amount.

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.

1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

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.

07/18 i. The services for Safety Net hospitals are effective on or after July 1, 2014 through June 30, 2018. 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. of Attachment 4.19-A.

C. Policy adjustment factor effective State fiscal year 2015 through 2018 is 1.3218.

07/18 ii. The services for High Outpatient Volume hospitals are effective on or after July 1, 2014 through June 30, 2018. Qualifying criteria:

A. The service is described in b.1. of this Chapter, excluding Medicare crossover claims.

B. The hospital is a High Outpatient Volume hospital, as defined in subsection d.iv., 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. of Attachment 4.19-A.

3. A Safety Net hospital, as defined in Chapter XV. K. of Attachment 4.19-A.

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 through 2018 is 1.3218.

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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:

07/18

2. Effective on or after July 1, 2014 through June 30, 2018, 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.

07/18

B. Crossover Adjustment Factor effective State fiscal year 2015 and 2016 is 0.98912. Effective July 1, 2018 through June 30, 2020, the Crossover Adjustment Factor is defined in iii.A. above, except that the outpatient base period paid claims data is the outpatient base period claims data.

iv. If a claim does not qualify for a Policy Adjustment described in subsection f.i. through f.v. of this Section, the policy adjustment factor is 1.0.

07/18

v. Reimbursement for High Outpatient Volume hospital services provided on or after July 1, 2018 through June 30, 2020.

A. High Outpatient Volume Hospital is defined as:

1. Illinois hospital for which the high outpatient volume is at least one and one -half standard deviations above the mean regional high outpatient volume;

2. Illinois hospital for which the high outpatient volume is at least one and one-half standard deviations above the mean statewide high outpatient volume;

3. Illinois Safety-Net hospital as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A; or

4. Illinois small public hospital as defined in subsection a. of Chapter 51.

5. Illinois hospital which qualified as a high outpatient volume hospital as of July 1, 2014.

B. Policy adjustment factor is set:

1. For acute care claims such that total expenditures on claims qualifying for a policy adjustor less the rate reductions defined in Chapter 46 of this Attachment is increased by $79.2 million more than base period qualifying claims allowed amount.

2. For non-acute care claims to equal the factor in place prior to July 1, 2018, as defined in subsection f.ii.D. of this Chapter.

1.1. Reimbursement for Hospital Outpatient and Provider-Based Clinic Services Effective for Services on or after July 1, 2014.

j. 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.

07/18 "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. Effective July 1, 2018 through June 30, 2020, "EAPG grouper" means the EAPG grouper version 3.11 of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by 3M Health Information Systems.

"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.

07/18 "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. Effective July 1, 2018 through June 30, 2020, "estimated cost of outpatient base period claims data" means the product of (i) outpatient base period claims data total covered charges, (ii) the critical access hospital's detailed ancillary cost-to-charge ratios, 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 described in Section (b)(i) provided during the high-volume outpatient base period paid claims data.

j. Definitions Continued

07/18 Effective July 1, 2018 through June 30, 2020, for in-state "Outpatient base period claims data" means State fiscal year 2015 outpatient Medicaid fee-for-service paid claims data and completed MCO encounter claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2019 and 2020.

07/18 "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. Effective July 1, 2018 through June 30, 2020, "outpatient crossover claims data" means State fiscal year 2015 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 2019 and 2020.

"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.

07/18 "Allowed amounts" means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for fiscal year 2015 MCO encounter data adjusted with a completion factor and fee-for-service claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims.

07/18 "In-state" means (1) all Illinois hospitals, and (2) out-of-state hospitals that are designated a level I pediatric trauma center or a level I trauma center by the Illinois Department of Public Health as of December 1, 2017,

07/18 "Detailed ancillary cost-to-charge ratios" means for each standardized ancillary Medicare cost-center cost-to-charge ratios for each hospital calculated by dividing total costs in Worksheet C, Part, 1, Column 5 and Worksheet B, Part 1, Columns 21 and 22 by total charges for each standardized ancillary Medicare cost center in Worksheet C, Part 1, Columns 6 and 7. For all hospitals missing Worksheet C, Part 1, Column 5 data, used Worksheet C, Part 1, Column 3 data. Used aggregate ancillary cost-to charge ratios as a default when a cost-center specific cost-to-charge ratio was not available or the claim revenue code was all-inclusive ancillary.

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07/18 k. Expensive Drugs and Devices Add-On Payment

i. Qualifying Criteria: In addition to the statewide standardized amounts, the Department shall make an add-on payment for outpatient expensive devices and drugs beginning July 1, 2018 through June 30, 2020, for in-state hospitals as defined in subsection j. of this Chapter, excluding critical access hospitals. This add-on payment shall apply to claim lines that:

A. Are assigned with one of the following EAPGs: 490, 1001 to 1020, and coded with one of the following revenue codes: 0274 to 0276, 0278; or

B. Are assigned with one of the following EAPGs: 430 to 441, 443, 444, 460 to 465, 495, 496, 1090.

ii. Payment: The add-on payment shall be calculated as follows:

A. The product of the following:

1. The claim line's covered charges.
2. The hospital's total acute cost to charge ratio as defined in subsection iii. of this Section.

B. The sum of:

1. The claim line's EAPG payment.
2. $1,000.

C. The product of:

1. The difference between subsections ii.A. and ii.B of this Section.
2. 0.8.

iii. Definitions

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:

A. 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 as published annually in the Inpatient PSF located on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_SAS.html to be updated annually with the 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.

B. For non-Medicare IPPS, the outlier cost-to-charge ratio is based on the sum of the Medicare 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 as published annually in the CMS IPPS Final Rule - Table 8 located on the CMS website for the fiscal year starting three months prior to the calendar year during which the discharge occurred, and effective at the beginning of the federal fiscal year. The location of the website is https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

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 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.

ii. 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., 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.

07/18 iii. For dates of service on or after July 1, 2014 through June 30, 2018, 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.

07/18 iv. For dates of service on or after July 1, 2014 through June 30, 2018, 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)

07/18 v. For dates of service on or after July 1, 2014 through June 30, 2018, 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., 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.

07/18 vi. For dates of service on or after July 1, 2014 through June 30, 2018, 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. 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.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. 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.

07/18 ix. For dates of service on or after July 1, 2014 through June 30, 2018, 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.

07/18 x. For dates of service on or after July 1, 2014 through June 30, 2018, 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. 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 $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.

07/18 ii. For hospitals qualifying under a.ii. above, the rate is $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 through June 30, 2018, the rate is $0.00. For dates of service on or after July 1, 2018, the rate is $290.

07/18 iii. Effective on or after July 1, 2014 through June 30, 2018, for hospitals qualifying under a.iii. above, the rate is $250.00

07/18 iv. Effective on or after July 1, 2014 through June 30, 2018, for hospitals qualifying under a.iv. above, the rate is $336.25

07/18 v. Effective on or after July 1, 2014 through June 30, 2018, for hospitals qualifying under a.v. above, the rate is $110.00

07/18 vi. Effective on or after July 1, 2014 through June 30, 2018, for hospitals qualifying under a.vi. above, the rate is $200.00

07/18 vii. For hospitals qualifying under a.vii. above, the rate is $247.50 for dates of service on or after July 1, 2014 through March 31, 2017. For dates of service on or after April 1, 2017 through June 30, 2018, the rate is $610.20. For dates of service on or after July 1, 2018, the rate is $154.

07/18 viii. For hospitals qualifying under a.viii. above, the rate is $205 effective July 1, 2014. Effective July 1, 2018, the rate is $70.00.

07/18 ix. Effective on or after July 1, 2014 through June 30, 2018, for hospitals qualifying under a.ix. above, the rate is $65.

07/18 x. Effective on or after July 1, 2014 through June 30, 2018, for hospitals qualifying under a.x. 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.

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31. Hospital Outpatient Assistance Adjustment Payments (continued)

c. Payment to a Qualifying Hospital

1. 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.

2. 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.

07/18 3. Effective July 1, 2018 through June 30, 2020, the product of subsection c.1. will be multiplied by the applicable tiering of Chapter XVI.O.4. of Attachment 4.19-A.

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07/18 **32. Reserved.**

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07/18 **39. Reserved.**

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07/18 [MATERIAL REMOVED]

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07/18 **40. Reserved.**

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07/18 **41. Reserved.**

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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07/18 **42. Reserved.**

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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07/18 **43. Reserved.**

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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07/18 **44. Reserved.**

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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07/18 **45. Reserved.**

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—
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07/18 **49. General Provisions effective through June 30, 2020.**

Unless otherwise indicated, the following apply to Chapters 50 through 52.

a. Payments.

i. Effective July 1, 2018, payments shall be paid in 12 installments on or before the 7th State business day of the month.

ii. The Department may adjust payments made under these Chapters to comply with federal law or regulations regarding disproportionate share, hospital-specific payment limitations on government-owned or government-operated hospitals as described in Chapter VI.C.7.g.iv.D. of Attachment 4.19-A.

iii. If the state or federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under these Chapters is exceeded, then the payments under these Chapters that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the federal limit.

b. Definitions. As used in this Section, unless the context requires otherwise:

"Hospital" means Illinois hospital except as otherwise noted in Chapters 50 through 52.

"MIUR" means Medicaid inpatient utilization rate for rate year 2017.

"Outpatient services" means, for a given hospital, the sum of the number of outpatient encounters identified as unique services provided to recipients of medical assistance under Title XIX of the Social Security Act for general acute care, psychiatric care, and rehabilitation care, excluding outpatient services for individuals eligible for Medicare under Title XVIII of the Social Security Act (Medicaid/Medicare crossover services), as tabulated from the Department's paid claims data for outpatient services occurring during State fiscal year 2015 that was adjudicated by the Department through October 28, 2016.

"Region" as defined in Chapter 1.1. of this Attachment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—

OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

07/18 **50. Safety-net hospital, private critical access hospital, and outpatient high volume access payment effective July 1, 2018 through June 30, 2020.**

a. Qualifying Criteria. A hospital qualifies for this payment if the hospital is one of the following:

i. Safety-net hospital, as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A, for Rate Year 2017 that is not publicly owned.

ii. Critical access hospital that is not publicly owned.

iii. A Tier 1 hospital that is not publicly owned.

iv. A Tier 2 hospital that is not publicly owned.

v. A Tier 3 hospital that is not publicly owned.

b. Payment: Outpatient access payments shall be determined as follows:

i. Each hospital qualifying under subsection a.1. of this section, shall receive a payment that is equal to the product of:

A. $40,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 outpatient services; and

2. the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment.

ii. Each hospital qualifying under subsection a.2. of this section, shall receive a payment that is equal to the product of:

A. $55,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 outpatient services; and

2. the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment.

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50. Safety-net hospital, private critical access hospital, and outpatient high volume access payment effective July 1, 2018 through June 30, 2020. (Continued)

iii. Each hospital qualifying under subsection a.3. of this section, shall receive a payment that is equal to the product of:

A. $25,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 outpatient services and;

2. the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment.

iv. Each hospital qualifying under subsection a.4. of this section, shall receive a payment that is equal to the product of:

A. $25,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 outpatient services; and

2. the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment.

v. Each hospital, qualifying under subsection a.5. of this section, shall receive a payment that is equal to the product of:

A. $58,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 outpatient services; and

2. the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals eligible under this paragraph for this payment.

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07/18 **50. Safety-net hospital, private critical access hospital, and outpatient high volume access payment effective July 1, 2018 through June 30, 2020. (Continued)**

c. Definitions:

i. A Tier 1 outpatient high volume hospital means one of the following:

A. a non-publicly owned hospital, excluding a safety net hospital as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A for Rate Year 2017, with total outpatient services, equal to or greater than the regional mean plus one standard deviation for all hospitals in the region but less than the mean plus 1.5 standard deviation;

B. an Illinois non-publicly owned hospital with total outpatient service units equal to or greater than the statewide mean plus one standard deviation; or

C. a non-publicly owned safety net hospital as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A for Rate Year 2017, with total outpatient services, equal to or greater than the regional mean plus one standard deviation for all hospitals in the region.

ii. A Tier 2 outpatient high volume hospital means a non-publicly owned hospital, excluding a safety-net hospital as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A for Rate Year 2017, with total outpatient services equal to or greater than the regional mean plus 1.5 standard deviations for all hospitals in the region but less than the mean plus 2 standard deviations.

iii. A Tier 3 outpatient high volume hospital means a non-publicly owned hospital, excluding a safety-net hospital as defined in subsection F-1.4.b. of Chapter IV of Attachment 4.19-A for Rate Year 2017, with total outpatient services equal to or greater than the regional mean plus 2 standard deviations for all hospitals in the region.

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07/18 **51. Small public hospital access payment effective July 1, 2018 through June 30, 2020.**

a. Qualifying Criteria: As used in this subsection, "small public hospital" means any Illinois publicly owned hospital which is not a "large public hospital" as defined in Chapter VII of Attachment 4.19-A.

b. Payment: Each small public hospital shall be paid an outpatient access payment equal to the product of:

i. $24,000,000

ii. A quotient of:

A. the numerator of which is the hospital's Fiscal Year 2015 outpatient services; and

B. the denominator of which is the Fiscal Year 2015 outpatient services for all hospitals under this paragraph for this payment.

52. Simulated Base Rate Adjustment effective July 1, 2018 through June 30, 2020.

a. Qualifying criteria. Non-publicly owned hospitals qualifying for this payment include:

1. General acute care hospitals located in Illinois
2. Psychiatric hospitals located in Illinois
3. Rehabilitation hospitals located in Illinois
4. Children's hospitals located in Illinois
5. Children's hospitals located in St. Louis that are designated a Level III perinatal center by the Illinois Department of Public Health and also designated a Level I pediatric trauma center by the Illinois Department of Public Health as of December 1, 2017

b. Definitions

1. Tier 1: A hospital with a MIUR equal to or greater than 60% shall have a service credit factor of 200%.
2. Tier 2: A hospital with a MIUR equal to or greater than 33% but less than 60% shall have a service credit factor of 100%.
3. Tier 3: A hospital with a MIUR equal to or greater than 20% but less than 33% shall have a service credit factor of 50%.
4. Tier 4: A hospital with a MIUR less than 20% shall have a service credit factor of 10%.

c. Payment. Each Illinois hospital and other hospitals authorized under this subsection shall be assigned a pool allocation percentage that is equal to the ratio of:

1. the hospital's estimated FY 2019 claims-based payments including all applicable FY 2019 policy adjusters,
2. multiplied by the applicable service credit factor for the hospital,
3. divided by the total of the FY 2019 claims-based payments including all FY 2019 policy adjusters adjusted by each hospital's applicable service credit factor for all qualified hospitals.
4. A hospital shall receive a supplemental payment equal to its pool allocation percentage multiplied by the total pool amount of $328,828,641.

53. Trauma care access payment effective July 1, 2018 through June 30, 2020.

a. Qualifying Criteria: To qualify for a Trauma care access payment, a hospital shall meet one of the following criteria:

i. Illinois non-publicly owned hospital designated a Level I trauma center by the Illinois Department of Public Health as of December 1, 2017.

ii. Illinois non-publicly owned hospital designated a Level II trauma center by the Illinois Department of Public Health as of December 1, 2017.

b. Payment: Trauma care access payments shall be determined as follows:

i. Each hospital qualifying under subsection a.i. of this section, shall be paid a Trauma care access payment equal to the product of:

A. $160,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and

2. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.

ii. Each hospital qualifying under subsection a.ii. of this section, shall be paid a Trauma care access payment equal to the product of:

A. $200,000,000

B. A quotient of:

1. the numerator of which is the hospital's Fiscal Year 2015 total admissions; and

2. the denominator of which is the Fiscal Year 2015 total admissions for all hospitals eligible under this paragraph for this payment.