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State/Territory Name: IL

State Plan Amendment (SPA) #: 26-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Financial Management Group

September 10, 2026

Laura Phelan, Director
Department of Healthcare and Family Services
Bureau of Program and Policy Coordination
201 South Grand Avenue East
Springfield, IL 62763-0001

RE: TN 26-0007

Dear Director Phelan,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Illinois State Plan Amendment (SPA) to Attachments 4.19-A and 4.19-B TN: #26-0007 which was submitted to CMS on June 29, 2026. This plan amendment proposes to make a technical correction to update the name of the grouping software utilized from 3M to Solventum, as well as updates the Diagnosis-Related Group (DRG) and the Enhanced Ambulatory Patient Groups (EAPG) grouping software from every 3 years to every 4 years to align with state law.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the State, we have approved the amendment with an effective date of April 11, 2026. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Matthew Klein at 214-767-4625 or matthew.klein@cms.hhs.gov

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0007

2. STATE: IL

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 11, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.10

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Pages 19, 20, 30.4A, 30.5, 30.6, 30.7,187,and 189
Attachment 4.19-B page 21.1 and page 22.1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, Pages 19(17-0012), 20(17-0012), 30.4A(25-0001), 30.5(20-0005), 30.6(20-0005), 30.7 (23-0032),187(18-0005), and 189(18-0005)
Attachment 4.19-B page 21.1(20-0005) and page 22.1 (14-0014A)

9. SUBJECT OF AMENDMENT

Grouping software updates.

10. 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
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Laura Phelan

13. TITLE
Director of Healthcare and Family Services

14. DATE SUBMITTED
06/29/26

15. RETURN TO
Department of Healthcare and Familt Services
Bureau of Program and Policy Coordination
Attn: Kristin Hartsaw
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR CMS USE ONLY

16. DATE RECEIVED
June 29, 2026

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 11, 2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Instructions on Back

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

01/13 4. Adjustments for Potentially Preventable Readmissions

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

a. Potentially Preventable Readmission (PPR) Criteria.

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

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

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

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

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

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

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

C) The admission was for an individual who was dually eligible for Medicare and Medicaid.

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

10/17

E) Effective October 1, 2017 and each state fiscal year thereafter, admissions was for the purpose of securing treatment for sickle cell anemia.

iii. Non-events are admissions to a non-acute care facility such as a nursing home or an admission to an acute care hospital for non-acute care. Nonevents are ignored and are not considered to be a readmission.

iv. Planned readmissions as defined by Solventum's team of clinicians are accounted for in the Solventum PPR software as an "only admission" and are not considered to be a readmission.

b. Methodology to Determine Excess Readmissions.

07/13

i. For State Fiscal Year 2013.

A) The baseline to determining any rate adjustment for State fiscal year 2013 for each hospital shall be based on each hospital's 2010 medical assistance paid claims data for admissions that occurred between July 1, 2009, and June 30, 2010.

B) The targeted rate of readmission for each hospital shall be adjusted by the percent necessary to achieve a savings of at least $40 million in State fiscal year 2013 for hospitals other than the "large public hospitals" defined in Chapter XXI.

C) Excess readmissions for each hospital shall be calculated by multiplying a hospital's qualifying admissions by the difference between the actual rate of PPRs and the targeted rate of PPRs. Each hospital's targeted rate is described at: www2.illinois.gov/hfs/MedicalProvider/PPRReports/Pages/default.aspx

D) In the event the actual rate of PPRs for a hospital is lower than the targeted rate of PPRs, the excess number of readmissions shall be set at zero.

07/13

ii. For State Fiscal Year 2014 and thereafter.

A) The targeted rate of readmission for the Current Year 2014 shall be based on the inpatient hospital medical assistance services provided in the data year of 2011 for admissions that occurred between July 1, 2010 and June 30, 2011. The data year will be updated one year for determining the targeted rate of readmission for each Current Year thereafter.

B) The average statewide expected rate of readmission will be multiplied by .85 for acute services and .90 for behavioral health services. This multiplication factor sets a goal that is specific to each hospital that lowers the target rate of readmission rather than maintaining the statewide average.

C) A Pediatric/Behavioral Health Factor is applied to those services provided at a Tier I Pediatric Intensive Care Unit (PICU) to account for the higher PPR rate for the higher acuity children.

iii. Effective for dates of service from January 1, 2026, through December 31, 2026, the Safety Net policy adjustment factors in 4.b.i.A through 4.b.i.C of this section shall be adjusted January 1, 2026, by applying a uniform factor to spend an approximate amount of $50,000,000 in calendar year 2026 using state fiscal year 2024 general acute care days and psychiatric days, excluding Medicare dual eligible days, for all qualifying hospitals as the basis.

iv. Effective for dates of service from July 1, 2024, through December 31, 2026, the Safety Net policy adjustment factor shall be increased by $200 per day for low volume safety net hospitals.

A. For dates of service from July 1, 2024, through December 31, 2025, low volume is defined as a safety net hospital providing less than 11,000 inpatient acute care and psychiatric care days, excluding Medicare dual eligible days, during state fiscal year 2022 for admissions received by the Department prior to October 1, 2023.

B. For dates of service from January 1, 2026, through December 31, 2026, low volume is defined as a safety net hospital providing less than 11,000 inpatient acute care and psychiatric care days, excluding Medicare dual eligible days, during state fiscal year 2023 for admissions received by the Department prior to October 1, 2024.

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.

04/26 H-1. Updates to DRG PPS reimbursement. Effective April 11, 2026, the Department may annually review the components as listed in subsection C-1 and make adjustments as needed. The Grouper Software shall be updated at least every four years and no more frequently than annually.

01/16 I-1. For Large Public Hospitals as defined in Chapter VII, excluding those maintained by the Illinois Department of Human Services, 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 Solventum Health Information Systems, Inc for the DRG grouper.

07/20 "DRG grouper" means the version of the All Patient Refined Diagnosis Related Grouping (APR-DRG) software distributed by Solventum Health Information Systems, Inc being used by the Department for pricing fee-for-service hospital inpatient acute care claims.

"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 Solventum Health Information Systems, Inc 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 Solventum 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 Solventum 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, a more 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 Solventum Health Information Systems, Inc 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.

01/24 "Statewide standardized amount" means the average amount, as the basis for the DRG base rate established by the department, of simulated DRG PPS payments from the general acute hospital inpatient base period paid claims data, such that, the total simulated DRG PPS payments, without the GME factor adjustments, is equal to the sum of the inpatient base period paid claims data allowed amount.

Effective January 1, 2024, the "statewide standardized amount" is increased by 10%.

"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).

07/20 Effective July 1, 2018, "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.

01/24 Effective January 1, 2024, "allowed amounts" means the calculated fee schedule amount prior to any adjustment for secondary payer amounts for inpatient priced claims via the DRG-PPS, except Medicare dual eligible claims which are included up to the amount of Medicaid liability on the claim, for which the date of discharge is in inpatient base period claims data.

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 Solventum Health Information Systems, Inc 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 Solventum Health Information Systems, Inc 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.

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 Solventum Health Information Systems, Inc 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.

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.

07/20 "Default EAPG settings" means the default EAPG grouper options in Solventum's Core Grouping Software for each EAPG grouper version, except where the Department made adjustments.

"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.

07/20 "EAPG grouper" means the version-of the Enhanced Ambulatory Patient Group (EAPG) software, distributed by Solventum Health Information Systems, Inc being used by the Department for pricing hospital outpatient services.

"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 Solventum Health Information Systems, Inc for the EAPG grouper, and (ii) the Illinois experience adjustment.

07/20 "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, "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

"High volume outpatient base period paid claims data" means state fiscal year 2011 outpatient Medicaid fee-for-service paid claims data, excluding Medicare dual eligible claims, renal dialysis claims, and therapy claims, for EAPG PPS payment for services provided in State fiscal years 2015 and 2016. For subsequent dates of service, the State fiscal year ending 30 months prior to the beginning of the calendar year during which the service is provided.

"Illinois experience adjustment" means for the calendar year beginning January 1, 2014, a factor of 1.0; for subsequent calendar years, means the factor applied to Solventum EAPG national weighting factors when updating EAPG grouper versions determined such that the arithmetic mean EAPG weighting factor under the new EAPG grouper version is equal to the arithmetic mean EAPG weighting factor under the prior EAPG grouper version using outpatient base period claims data.

"Labor-related share" means that portion of the statewide standardized amount that is allocated in the EAPG PPS methodology to reimburse the costs associated with personnel. The Labor-related share for a hospital is 0.60.

"Mean regional high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(i)(A) through (D) of this Section, provided by hospitals within a region, based on outpatient base period paid claims data.

"Mean statewide high outpatient volume" means the quotient, rounded to the nearest tenth, resulting from the number of paid outpatient services described in subsections (b)(i)(A) through (D) of this Section, provided by hospitals within the state, based on outpatient base period paid claims data.

"Medicare IPPS wage index" means for in-state providers and out-of-state Illinois Medicaid cost reporting providers, the wage index used for inpatient reimbursement is based on the Medicare inpatient prospective payment system post-reclass wage index effective at the beginning of the federal fiscal year starting three months prior to the calendar year during which the discharge occurred; except for the calendar year beginning January 1, 2014, the Medicare inpatient prospective payment system hospital post-reclass wage index effective October 1, 2012. . For out-of-state non-cost reporting providers, the wage index used to adjust the EAPG standardized amount shall be a factor of 1.0.

"Non-labor share" means the difference resulting from the labor-related share being subtracted from 1.0.

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