DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SECOND NOTICE OF PROPOSED RULEMAKING

1) Agency Name: Department of Healthcare and Family Services

2) Subject of Proposed Rulemaking: Hospital provider payment changes

Heading of the Part: Hospital Services

Code Citation: 89 Ill. Adm. Code 148

3) Date of Proposed Rulemaking: November 29, 2010

Illinois Register Citation: 34 Ill. Reg. 17832

Summary of Proposed Rulemaking: This proposed rulemaking consist of the following changes:

- The proposed amendment increases payments to Critical Access Hospitals as authorized by P.A. 96-1382. This legislation authorizes the Department to reimburse critical access hospitals for outpatient services at an amount no less than the cost of providing such services, based upon Medicare cost principles. The amount of this increase will be approximately $33.5 million annually.

- IMD Classification - These changes are necessary in order to assure federal compliance. There is no fiscal impact as a result of this rule change.

- Hospital Specific Requests - The total fiscal impact as a result of the rule change is $8.25 million.

4) Text and Location of Changes Made to the Proposed Rulemaking During the Public Comment Period: The following changes have been made:

In subsection (a)(4) of Section 148.40, deleted "~~Hospitals classified as IMDs pursuant to 89 Ill. Adm. Code 148, Subpart E may not receive reimbursement for services provided to patients over the age of 20 or under the age of 64, except as described in Section 148.750.~~" and added:"Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his/her 21st birthday, reimbursement for psychiatric services shall be provided until the earliest of the following:

A) The date the patient no longer requires the services; or

B) The date the patient reaches 22 years of age."

In subsection (b)(9) of Section 148.117, changed to read as follows: "(9) For hospitals qualifying under subsection (a)(9), the rate is $128.50 through June 30, 2010. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $74.00, to $202.50. For dates of service on or after July 1, 2012, the rate is $48.50."

In subsection (b)(10) of Section 148.117, added to the end of the paragraph "For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $70.00, to $205.00."

Added new subsection (e) to Section 148.117 to read as follows: "(e) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in *305 ILCS 5/5-30* must be a Coordinated Care Participating Hospital as defined in 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area."

In subsection (c)(9) of Section 148.126 changed language to read as follows: "(9) For a hospital qualifying under subsection (a)(9) of this Section, the rate is $133.00. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $72.00, to $205.00. For dates of service on or after July 1, 2012, the rate is $85.50."

In subsection (c)(10) of Section 148.126 changed language to read as follows: "(10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is $13.75. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $25.00, to $38.75."

In subsection (c)(18) of Section 148.126 changed language to read as follows: "(18) For a hospital qualifying under subsection (a)(19) of this Section, the rate is $229.00. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $113.00, to $342.00. For dates of service on or after July 1, 2012, the rate is $145.00."

Added new subsection (f) to Section 148.126 to read as follows: "f) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the state in which the Department

mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in *305 ILCS 5/5-30* must be a Coordinated Care Participating Hospital as defined in 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area."

Deleted all of subsection (b)(6) of Section 148.140 and replaced with the following language:"(6) Critical Access Hospital Rate Adjustment

Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485, Subpart F shall be eligible for an outpatient rate adjustment for services identified in subsection (b)(1)(A) – (b)(1)(F) excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:

A) An annual distribution factor shall be calculated as follows;

i) The numerator of which shall be $33 million.

ii) The denominator of which shall be the RY-2011 total outpatient cost coverage deficit calculated in accordance 89 IL Admin Code 148.115, less the RY-2011 Rural Adjustment outpatient Payments calculated in accordance with to 89 IL Admin Code 148.115 plus the annual outpatient supplemental payment calculated in accordance with 89 IL Admin Code 148.456.

B) Hospital Specific Adjustment Value;

For each hospital qualified under this subsection (6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in (A) (ii) of this section and the distribution factor calculated in (A) of this section.

C) Final APL Rate Adjustment Values shall be the quotient of;

i) The Hospital Specific Adjustment Value identified in (6)(B) of this Section divided by;

ii) The total outpatient services identified in subsection (b)(1)(A) - (b)(1)(F) excluding services for

Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the departments paid claims database as of December 31, 2010.

D) Non-State Government owned provider adjustment

Final APL rates for hospitals identified as Non-State government owned or operated providers in the state's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.

E) Applicability

The rates calculated in accordance with subsection (6)(A) of this Section shall be effective for dates of service beginning January 1, 2011and shall be adjusted each State fiscal year beginning July 1, 2011.

i) For State fiscal year 2011 the rate year shall begin January 1, 2011 and end June 30, 2011.

ii) For State fiscal year 2012 and beyond the rate year shall be for dates of service beginning July 1 through June 30 of the subsequent year.

iii) For purposes of this adjustment children's hospital identified in 149.50(c)(3)(b), shall be combined with the corresponding general acute care parent hospital.

iv) Beginning with State fiscal year 2012 and each subsequent state fiscal year thereafter, the adjustment to the FY-2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5."

In Section 148.295, at the end of the paragraph added, "For a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 *ILCS* 5/5-30, no new payment or rate increase that would otherwise be effective for dates of service on or after July 1, 2010, shall take effect under this Section unless the qualifying hospital also meets the definition of a

Coordinated Care Participating Hospital as defined in subsection (g)(5) of this Section, no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care program."

In subsection (b) of Section 148.295, added "free-standing acute comprehensive" in front of "rehabilitation hospitals"; added "or the Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare facilities)" after the word "(CARF)" and deleted "~~three~~" and added "four".

In subsection (c)(2)(D)(iii) of Section 148.295, changed"~~$620.00~~" to "$573.00 per day", and added "For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by an additional $47.00, to $620.00." and deleted "~~For dates of service on or after July 1, 2012, the rate is $573.00.~~"

In subsection (c)(2)(E)(iv) of Section 148.295, after the word "additional" added, "$41.00 per day. For dates of service on or after July 1, 2010 through June 30, 2012 this rate shall be further increased by $54.00 per day, to $95.00 per day." and deleted "~~For dates of service on or after July 1, 2012, the rate is $41.00.~~".

In subsection (g)(5) of Section 148.295, renumbered "(5)" to "(6)" and added new (5) to read as follows:

"" Coordinated Care Participating Hospital" means a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 *ILCS* 5/5-30 that is one of the following:

A) Has entered into a contract to provide hospital services to enrollees of the care coordination program.

B) Has not been offered a contract by a care coordination plan that pays no less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that the Department pays directly.

C) Is not licensed to serve the population mandated to enroll in the care coordination program."

In subsection (g)(5) of Section 148.295, renumbered "(5)" to "(6)"

In subsection (g)(6) of Section 148.295 renumbered "(6)" to "(7)"

In subsection (g)(7) of Section 148.295 renumbered "(7)" to "(8)"

In subsection (g)(8) of Section 148.295 renumbered "(8)" to "(9)"

In subsection (g)(9) of Section 148.295, renumbered "(9)" to "(10)"

In subsection (g)(10) of Section 148.295, renumbered "(10)" to "(11)"

In subsection (g)(11) of Section 148.295, renumbered "(11)" to "(12)"

In subsection (g)(12) of Section 148.295, renumbered "(12)" to "(13)"

In subsection (g)(13) of Section 148.295, renumbered "(13)" to "(14)"

In subsection (g)(14) of Section 148.295, renumbered "(14)" to "(15)"

In subsection (g)(15) of Section 148.295, renumbered "(15)" to "(16)"

In Section 148.700, after the word "shall" added "collect information necessary to assure federal compliance." and deleted "~~identify hospitals that are IMDs or that are at risk of becoming IMDs, the preventive measures to be taken to avoid classification of a hospital as an IMD, and the actions to be taken if a hospital is identified as an IMD.~~" Added the following new subsections:

"(a) The Department shall request certain data elements from participating hospitals that includes but is not limited to daily census information as described in provider notices to hospitals.

(b) Participating hospitals shall be notified no less than 90 days before the effective reporting period.

Sections 148.710, 148.720, 148.730, 148.740, 148.750, 148.760, ALL DELETED.

5) Response to Recommendations Made by the Administrative Code Division:

6) Incorporation by Reference: This proposed rulemaking does not include any incorporation by reference.

7) Final Regulatory Flexibility Analysis:

A) The Department did not receive any comments from small businesses or local governmental units regarding this proposed rulemaking.

B) No alternatives to the proposed rulemaking were suggested by small businesses or local governmental units.

8) Compliance with Small Business Flexibility Requirements: This rulemaking has no effect on small businesses or units of local government. No action is required with respect to Section 5-30 of the Illinois Administrative Procedure Act.

9) Agency's Evaluation of Submissions by Interested Persons During the Public Comment Period:

A) List of individuals and groups submitting comments: Comments were received from the following individuals:

Maureen A. Kahn, President/CEO
Blessing Hospital
P.O. Box 7005
Quincy, IL 62305-7005

Kenneth G. Reid, President/CEO
Carlinville Area Hospital
20733 North Broad Street
Carlinville, IL 62626

Don Annis, CEO
Crawford Memorial Hospital
1000 North Allen Street
Robinson, IL 62454

Lynn Stambaugh, CEO
Culbertson Memorial Hospital
238 South Congress
Rushville, IL 62681

Earl N. Sheehy, CEO
Dr. John Warner Hospital
422 West White Street
Clinton, IL 61727-2199

Timothy J. O'Brien
Fletcher, O'Brien, Kasper & Nottage, P.C.
222 North LaSalle Street
Chicago, IL 60601-1013

Randall W. Dauby, CEO
Hamilton Memorial Hospital
611 South Marshall Avenue
McLeansboro, IL 62859

Connie L. Schroeder, President/CEO
Illini Community Hospital
640 West Washington Street
Pittsfield, IL 62363

Ada Bair, Board President
Pat Schou, Executive Director
Illinois Critical Access Hospital Network
245 Backbone Road E # B
Princeton, IL 61356-8652

Howard A. Peters III, Executive Vice President
Illinois Hospital Association
1151 East Warrenville Road
Naperville, IL 60566

William J. Huff, CEO
Marshall Browning Hospital
900 North Washington, P.O. Box 192
Du Quoin, IL 62832

Harry Wolin, Administrator, CEO
Mason District Hospital
615 North Promenade
Havana, IL 62644

Shawn Holt, Director, Patient Financial Services
Northwestern Lake Forest Hospital
660 North Westmoreland Road
Lake Forest, IL 60045-6081

Rex D. Conger, President/CEO
Perry Memorial Hospital
530 Park Avenue
Princeton, IL 61356

Thomas J. Hudgins, Administrator/CEO
Pinckneyville Community Hospital
101 N. Walnut Street
Pinckneyville, IL 62274

Anthony J. Filer, CEO
Provena Health
19065 Hickory Creek Drive, Suite 300
Mokena, IL 60448

Richard A. Seidler, President/CEO
Robert Young Center/Trinity Health System
2701 17th Street
Rock Island, IL 61201

Mark Newton, President/CEO
Swedish Covenant Hospital
5145 N. California Avenue
Chicago, IL 60625

Michael J. Muzzillo, Vice President of Operations
Valley West Community Hospital
11 E. Pleasant Avenue
Sandwich, IL 60548

B) Specific criticisms, suggestions, and comments raised: See Attachment Four

C) Changes made as a result of public comments: See Attachment Four

D) Public hearings: No public hearings on these proposed amendments were requested or held.

10) Justification and Rationale for the Proposed Rulemaking:

A) Changes in Illinois laws that require the rulemaking: P.A. 96-1382.

B) Changes in agency policies and procedures that require the rulemaking: None

C) Federal laws, rules or funding requirements which require the rulemaking: None

D) Court orders or decisions which require the rulemaking: None

E) Any other reasons for the rulemaking: None

11) Agency Personnel Who Will Respond to Joint Committee Questions Regarding the Proposed Rulemaking: Please address any questions to:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/782-1233

12) State Mandates Act Questionnaire: See Attachment Two.

13) Analysis of Economic and Budgetary Effects of the Proposed Rulemaking: See Attachment Three.

14) Impact Statement from Department of Commerce and Economic Opportunity: The Department of Commerce and Economic Opportunity has indicated that these proposed amendments will not adversely affect small businesses.

ATTACHMENT ONE

FIRST NOTICE CHANGES

CHANGES IN THE TEXT OF THE PROPOSED AMENDMENTS
DURING THE FIRST NOTICE PERIOD

Agency: Department of Healthcare and Family Services

Heading of the Part: Hospital Services (89 Ill. Adm. Code 148)

Illinois Register Citation: 34 Ill. Reg. 17832

Changes:

The following changes have been made:

1. In lines 301-314, deleted "~~Hospitals classified as IMDs pursuant to 89 Ill. Adm. Code 148, Subpart E may not receive reimbursement for services provided to patients over the age of 20 or under the age of 64, except as described in Section 148.750.~~" and added

   "Federal Medicaid regulations preclude payment for patients over 20 or under 65 years of age in any Institution for Mental Diseases (IMD). Therefore, psychiatric hospitals may not receive reimbursement for services provided to patients over the age of 20 and under the age of 65. In the case of a patient receiving psychiatric services immediately preceding his/her 21st birthday, reimbursement for psychiatric services shall be provided until the earliest of the following:

   A) The date the patient no longer requires the services; or

   B) The date the patient reaches 22 years of age."

2. In lines 907-910, changed all to read as follows: "For hospitals qualifying under subsection (a)(9), the rate is $128.50 through June 30, 2010. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $74.00, to $202.50. For dates of service on or after July 1, 2012, the rate is $48.50."

3. In line 912 deleted all and added the following language: "For hospitals qualifying under subsection (a)(10), the rate is $135.00. For dates of service on or after July 1, 20100 through June 30, 2012, this rate shall be increased by $70.00, to $205.00."

4. In line 998 at the end of Section 148.117 added new subsection (e) to read as follows "(e) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the state in which the Department

mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in *305 ILCS 5/5-30* must be a Coordinated Care Participating Hospital as defined in 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area."

5. In lines 1360-1363, changed language to read as follows: "For a hospital qualifying under subsection (a)(9) of this Section, the rate is $133.00. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $72.00, to $205.00. For dates of service on or after July 1, 2012, the rate is $85.50."

6. In lines 1365-1367, changed language to read as follows: "(10) For a hospital qualifying under subsection (a)(10) of this Section, the rate is $13.75. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $25.00, to $38.75."

7. In lines 1395-1397, changed language to read as follows: "For a hospital qualifying under subsection (a)(19) of this Section, the rate is $229.00. For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by $113.00, to $342.00. For dates of service on or after July 1, 2012, the rate is $145.00."

8. In line 1496, added new subsection (f) to read as follows: "(f) Payment Limitations: In order to be eligible for any new payment or rate increase under this Section that would otherwise become effective for dates of service on or after July 1, 2010, a hospital located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in *305 ILCS 5/5-30* must be a Coordinated Care Participating Hospital as defined in 148.295(g)(5). This payment limitation takes effect six months after the Department begins mandatory enrollment in the geographic area."

9. In lines 1911 – 1955 deleted and replaced with the following language:
"(6) Critical Access Hospital Rate Adjustment
Hospitals designated by the Illinois Department of Public Health as Critical Access Hospital (CAH) providers in accordance with 42 CFR 485, Subpart F shall be eligible for an outpatient rate adjustment for services identified in subsection (b)(1)(A) – (b)(1)(F) excluding services for Medicare/Medicaid crossover claims. This adjustment shall be calculated as follows:

A) An annual distribution factor shall be calculated as follows;
i) The numerator of which shall be $33 million.

ii) The denominator of which shall be the RY-2011 total outpatient cost coverage deficit calculated in accordance 89 IL Admin Code 148.115, less the RY-2011 Rural Adjustment outpatient Payments calculated in accordance with to 89 IL Admin Code 148.115 plus the annual outpatient supplemental payment calculated in accordance with 89 IL Admin Code 148.456.

B) Hospital Specific Adjustment Value;

For each hospital qualified under this subsection (6) the hospital specific adjustment value shall be the product of each hospital's specific cost coverage deficit calculated in (A) (ii) of this section and the distribution factor calculated in (A) of this section.

C) Final APL Rate Adjustment Values shall be the quotient of;

i) The Hospital Specific Adjustment Value identified in (6)(B) of this Section divided by;

ii) The total outpatient services identified in subsection (b)(1)(A) - (b)(1)(F) excluding services for Medicare/Medicaid crossover claims for calendar year 2009, adjudicated and contained in the departments paid claims database as of December 31, 2010.

D) Non-State Government owned provider adjustment

Final APL rates for hospitals identified as Non-State government owned or operated providers in the state's Upper Payment Limits demonstration shall be adjusted when necessary to assure compliance with federal upper payment limits as stated in 42 CFR 447.304.

E) Applicability

The rates calculated in accordance with subsection (6)(A) of this Section shall be effective for dates of service beginning January 1, 2011 and shall be adjusted each State fiscal year beginning July 1, 2011.

i) For State fiscal year 2011 the rate year shall begin January 1, 2011 and end June 30, 2011.

ii) For State fiscal year 2012 and beyond the rate year shall be for dates of service beginning July 1 through June 30 of the subsequent year.

iii) For purposes of this adjustment children's hospital identified in 149.50(c)(3)(b), shall be combined with the corresponding general acute care parent hospital.

iv) Beginning with State fiscal year 2012 and each subsequent state fiscal year thereafter, the adjustment to the FY-2011 final APL Rate adjustment shall be limited to 2% in accordance with spending limits in 35 ILCS 5/201.5."

10. In line 2203, at the end of the sentence added, "For a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a Care Coordination program as defined in 305 *ILCS* 5/5-30 no new payment or rate increase that would otherwise become effective for dates of service on or after July 1, 2010, shall take effect under this Section unless the qualifying hospital also meets the definition of a Coordinated Care Participating Hospital as defined in subsection (g)(5) of this Section no later than six months after the effective date of the first mandatory enrollment in the Coordinated Care program."

11. In line 2315, added "free-standing acute comprehensive" in front of "rehabilitation hospitals".

12. In line 2317, added "or the Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare facilities)" after the word "(CARF)".

13. In line 2318, deleted "~~three~~" and added "four".

14. In lines 2547-2551, changed "~~$620.00 per day~~" to "$573.00 per day.", and added "For dates of service on or after July 1, 2010 through June 30, 2012, this rate shall be increased by an additional $47.00, to $620.00." and deleted "~~For dates of service on or after July 1, 2012, the rate is $573.00.~~"

15. In line 2589, after the word "additional" added, "$41.00 per day. For dates of service on or after July 1, 2010 through June 30, 2012 this rate shall be further increased by $54.00 per day, to $95.00 per day."

16. In lines 2590-2591, deleted "~~For dates of service on or after July 1, 2012, the rate is $41.00.~~".

17. In line 2689 renumbered "(5)" to "(6)" and added new (5) to read as follows:
""Coordinated Care Participating Hospital" means a hospital that is located in a geographic area of the state in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program as defined in 305 *ILCS* 5/5-30 that is one of the following:

    A) Has entered into a contract to provide hospital services to enrollees of the care coordination program.

    B) Has not been offered a contract by a care coordination plan that pays no less than the Department would have paid on a fee-for-service basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that the Department pays directly.

    C) Is not licensed to serve the population mandated to enroll in the care coordination program."

18. In line 2697, renumbered "(6)" to "(7)"

19. In line 2710, renumbered "(7)" to "(8)"

20. In line 2713, renumbered "(8)" to "(9)"

21. In line 2721, renumbered "(9)" to "(10)"

22. In line 2738, renumbered "(10)" to "(11)"

23. In line 2743 renumbered "(11)" to "(12)"

24. In line 2747 renumbered "(12)" to "(13)"

25. In line 2752 renumbered "(13)" to "(14)"

26. In line 2758 renumbered "(14)" to "(15)"

27. In line 2763 renumbered "(15)" to "(16)"

28. In line 2784, after the word "shall" added "collect information necessary to assure federal compliance." and deleted "~~identify hospitals that are IMDs or that are at risk of becoming IMDs, the preventive measures to be taken to avoid classification of a hospital as an IMD, and the actions to be taken if a hospital is identified as an IMD.~~" Added the following new subsections:

"(a) The Department shall request certain data elements from participating hospitals that includes but is not limited to daily census information as described in provider notices to hospitals.

(b) Participating hospitals shall be notified no less than 90 days before the effective reporting period.

(c) If a hospital does not provide the required information within the required deadlines as defined through a provider notice, the Department may suspend payments for covered services until the required information is received."

29. In lines 2790-2970 DELETED ALL

ATTACHMENT TWO

STATE MANDATES ACT QUESTIONNAIRE

Agency: Department of Healthcare and Family Services

Heading of the Part: Hospital Services (89 Ill. Adm. Code 148)

Illinois Register Citation: 34 Ill. Reg. 17832

1. Does this rulemaking affect a municipality, county, township, other unit of local government, school district or community college district?

   Yes ☐ No ☒

   If yes, please check the type of entity or entities that are affected.

   Municipality ☐
   County ☐
   Township ☐
   Other Unit of Local Government ☐
   School District ☐
   Community College District ☐

2. Does this rule require a unit of local government, a school district, or a community college district to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues?

   Yes ☐ No ☒

   Total number of units affected: _____

   If yes, please estimate the amount of additional expenditures necessitated by this rulemaking per unit of government: $____

   NOTE: If the dollar amount, or total number of units affected is unknown, please outline and attach to this form a specific and detailed explanation of the steps taken by the

agency to determine the approximate expense of the rulemaking, and the number of units affected.

If no, please explain why the rule does not necessitate such additional expenditures.

3. Were any alternatives to the rule, which did not necessitate additional expenditures considered?

Yes ☐ No ☒

If yes, please list these alternatives and explain why these alternatives were rejected.

4. What is the policy objective(s) of the rulemaking? (Please be specific)

The policy objectives of these proposed amendments are fully explained in the Notice of Proposed Amendments.

5. Please explain, in detail, why the policy objective(s) of this rule cannot be achieved in the absence of the rule.

The proposed amendment increases payments to Critical Access Hospitals as authorized by P.A. 96-1382 and the IMD Classification changes are necessary in order to assure federal compliance.

ATTACHMENT THREE

AGENCY ANALYSIS OF ECONOMIC AND BUDGETARY EFFECTS
OF PROPOSED RULEMAKING

Agency: Department of Healthcare and Family Services

Heading of the Part: Hospital Services (89 Ill. Adm. Code 148)

Illinois Register Citation: 34 Ill. Reg. 17832

Please attempt to provide as dollar-specific responses as possible and feel free to add any relevant narrative explanation.

1. Anticipated effect on State expenditures and revenues.

   (a) Current cost to the agency for this program/activity.

   Costs before proposed changes is approximately $ 11.4 million.

   (b) If this rulemaking will result in an increase or decrease in cost, specify the fiscal year in which this change will first occur and the dollar amount of the effect.

   The total fiscal impact as a result of the rule change is approximately $8.25 million increase in spending.

   (c) Indicate the funding source, including Fund and appropriation lines for this program/activity.

   General Revenue Fund, Hospital Line

   (d) If an increase or decrease in the costs of another State agency is anticipated, specify the fiscal year in which this change will first occur and the estimated dollar amount of the effect.

   There is no anticipation of an increase or decrease in costs associated with another State agency.

   (e) Will this rulemaking have any effect on State revenues or expenditures not already indicated above? Specify effects and amounts.

   This rulemaking will not have an effect on State revenues or expenditures not already mentioned.

2. Economic effect on entities regulated by the rulemaking.

(a) Indicate the economic effect and specify the entities affected:

Positive ☒ Negative ☐ No effect ☐
Entities Affected:

Dollar amount per entity: Unknown

Total Statewide cost: $8.25 million increase in spending

(b) If an economic effect is predicted, please briefly describe how the effect will occur. (Example: Additional continuing education courses will require expenditures for course fees.)

Supplemental payments will be paid to qualifying hospitals.

(c) Will the rulemaking have an indirect effect that may result in increased administrative costs? Will there be any change in requirements such as filing, documentation, reporting or completion of forms? Compare to current requirements.

This rulemaking will have no indirect effect that may cause an increase in administrative costs.