DEPARTMENT OF PUBLIC AID

NOTICE OF PROPOSED AMENDMENTS

SUBPART B: REIMBURSEMENT AND RELATED PROVISIONS

Section 148.105 Psychiatric Adjustment Payments

a) Qualifying Criteria
Psychiatric Adjustment Payments shall be made to a qualifying hospital, as defined in this subsection (a). A hospital not otherwise excluded under subsection (b) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:

1) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in subsection (e)(5) of this Section that is greater than 60 percent.

2) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) that is greater than 20 percent; has greater than 325 total licensed beds as described in subsection (e)(2) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 50 percent.

3) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 15 percent; has greater than 500 total licensed beds as described in subsection (e)(2) of this Section; has a psychiatric occupancy rate as described in subsection (e)(4) of this Section that is greater than 35 percent; and has total licensed psychiatric beds described in subsection (e)(3) of this Section that is greater than 50.

4) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in subsection (e)(5) of this Section that is greater than 19 percent; has less than 275 total licensed beds as described in subsection (e)(2) of this Section; has fewer than 1,000 total psychiatric care days as described in subsection (e)(8) of this Section; has 40 or fewer total licensed psychiatric beds as described in subsection (e)(3) of this Section; has greater than 6,000 total days as described in subsection (e)(9) of this Section.

5) The hospital is located in Illinois; is a general acute care hospital with a distinct part unit as defined in 89 Ill. Adm. Code 149.50(d)(1) enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has 50 or more total licensed psychiatric beds as described in subsection (e)(3) of this Section; and has a psychiatric occupancy rate described in subsection (e)(4) of this Section that is greater than 60 percent.

b) The following five classes of hospitals are ineligible for Psychiatric Adjustment Payments associated with the qualifying criteria listed in subsections (a)(1) through (a)(4) of this Section:

1) Hospitals located outside of Illinois.

2) Hospitals located inside HSA 6.

3) Psychiatric hospitals, as described in 89 Ill. Adm. Code 149.50(c)(1).

4) Long term stay hospitals, as described in 89 Ill. Adm. Code 149.50(c)(4).

5) A children’s hospital, as described in 89 Ill. Adm. Code 149.50(c)(3).

c) Psychiatric Adjustment Payment Rates

1) For a hospital qualifying under subsection (a)(1) of this Section, the rate is $63.00.

2) For a hospital qualifying under subsection (a)(2) of this Section that:

A) Has less than 10,000 total days, the rate is $78.00.

B) Has equal to or greater than 10,000 total days, the rate is $125.00.

3) For a hospital qualifying under subsection (a)(3) of this Section, the rate is $21.00.

4) For a hospital qualifying under subsection (a)(4) of this Section, the rate is $38.00.

5) For a hospital qualifying under subsection (a)(5) of this Section, the rate is $140.00

d) Payment to a Qualifying Hospital

1) The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (c) of this Section, multiplied by total days as described in subsection (e)(9) of this Section.

2) The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment period in installments on, at least, a quarterly basis.

e) Definitions

1) "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.

2) "Total licensed beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois".

3) "Licensed psychiatric beds" means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois

Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois”.

4) "Psychiatric occupancy rate" means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled “Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois.”

5) “MIUR” for a given hospital, has the meaning as defined in Section 148.120(k)(5), and shall be determined in accordance with Sections 148.120(c) and (f). For purposes of this rulemaking, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment Payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.

6) “Psychiatric Adjustment Payment base year” means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.

7) “Psychiatric Adjustment Payment period” means, beginning October 1, 2002, the nine month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003, the 12 month period beginning July 1 of the year and ending June 30 of the following year.

8) “Total psychiatric care days” means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Section 148.40(a), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s claims data for admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.

9) “Total days” means, for a given hospital, the sum of days of inpatient hospital services provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department’s claims data for

admissions occurring in the Psychiatric Adjustment Payment base year that were adjudicated by the Department through June 30, 2001.

10) "Psychiatric care average length of stay" means the quotient of the fraction, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which is the number of admissions in the Psychiatric Adjustment Payment base year.

(Source: Amended at 29 Ill. Reg. _____, effective _____)

Section 148.295 Critical Hospital Adjustment Payments (CHAP)

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25 (b)(1)(A), unless otherwise noted in this Section, and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25 (b)(1)(B), for inpatient admissions occurring on or after July 1, 1998, in accordance with this Section.

a) Trauma Center Adjustments (TCA)
The Department shall make a TCA to Illinois hospitals recognized, as of the first day of July in the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health (IDPH) in accordance with the provisions of subsections (a)(1) through (a)(3) of this Section.

1) Level I Trauma Center Adjustment.

A) Criteria. Illinois hospitals that, on the first day of July in the CHAP rate period, are recognized as a Level I trauma center by the Illinois Department of Public Health shall receive the Level I trauma center adjustment.

B) Adjustment. Illinois hospitals meeting the criteria specified in subsection (a)(1)(A) of this Section shall receive an adjustment as follows:

i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this

Section, shall receive an adjustment of $21,365.00 per Medicaid trauma admission in the CHAP base period.

ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under subsection (a)(1)(A) of this Section, shall receive an adjustment of $14,165.00 per Medicaid trauma admission in the CHAP base period.

2) Level II Rural Trauma Center Adjustment. Illinois rural hospitals, as defined in Section 148.25(g)(3), that, on the first day of July in the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period.

3) Level II Urban Trauma Center Adjustment. Illinois urban hospitals, as described in Section 148.25(g)(4), that, on the first day of July in the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of $11,565.00 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:

A) The hospital is located in a county with no Level I trauma center; and

B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the first day of July in the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(3) of this Section; or the hospital is not located in an HPSA and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(3) of this Section.

b) Rehabilitation Hospital Adjustment (RHA)
Illinois hospitals that, on the first day of July in the CHAP rate period, qualify as rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2), and that are accredited by the Commission on Accreditation of Rehabilitation Facilities

(CARF), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:

1) Treatment Component. All hospitals defined in subsection (b) of this Section shall receive $4,215.00 per Medicaid Level I rehabilitation admission in the CHAP base period.

2) Facility Component. All hospitals defined in subsection (b) of this Section shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:

A) Hospitals with fewer than 60 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $229,360.00 in the CHAP rate period.

B) Hospitals with 60 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $527,528.00 in the CHAP rate period.

3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) of this Section that are located in an HPSA on July 1, 1999, shall receive $276.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.

c) Direct Hospital Adjustment (DHA) Criteria

1) Qualifying Criteria
Hospitals may qualify for the DHA under this subsection (c) under the following categories:

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 an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999; or

iii) were county owned hospitals as defined in 89 Ill. Adm. Code 148.25(b)(1)(A), and had an MIUR equal to or greater than the statewide mean in Illinois on July 1, 1999.

B) Illinois hospitals located outside of HSA 6 that had an 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 under this subsection (c)(1)(B): children's hospitals; psychiatric hospitals; rehabilitation hospitals; and long term stay hospitals.

C) Children's hospitals, as defined under 89 Ill. Adm. Code 149.50(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 subsection (c)(1)(A), (B), or (C) of this Section.

E) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals qualifying in subsection (c)(1)(A), (B), (C) or (D) of this Section, all other hospitals located in Illinois that had an MIUR equal to or greater than the mean plus one-half standard deviation on July 1, 1999, and provided more than 15,000 Total days.

F) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A), (B), (C), (D), or (E) of this Section, all other hospitals that had an MIUR greater than 40 percent on July 1,

1999, and provided more than 7,500 Total days and provided obstetrical care as of July 1, 2001.

G) Illinois teaching hospitals with 25 or more graduate medical education programs on July 1, 1999, that are affiliated with a Regional Alzheimer's Disease Assistance Center as designated by the Alzheimer's Disease Assistance Act [410 ILCS 405/4], that had an MIUR less than 25 percent on July 1, 1999, and provided 75 or more Alzheimer days for patients diagnosed as having the disease.

H) Except for hospitals operated by the University of Illinois, children's hospitals, psychiatric hospitals, rehabilitation hospitals, long term stay hospitals and hospitals otherwise qualifying in subsection (c)(1)(A) through (c)(1)(G) of this Section, all other hospitals that had an MIUR greater than 50 percent on July 1, 1999.

2) DHA Rates

A) For hospitals qualifying under subsection (c)(1)(A) of this Section, the DHA rates are as follows:

i) Hospitals that have a Combined MIUR that is equal to or greater than the Statewide mean Combined MIUR, but less than one standard deviation above the Statewide mean Combined MIUR, will receive $69.00 per day for hospitals that do not provide obstetrical care and $105.00 per day for hospitals that do provide obstetrical care.

ii) Hospitals that have a Combined MIUR that is equal to or greater than one standard deviation above the Statewide mean Combined MIUR, but less than one and one-half standard deviation above the Statewide mean Combined MIUR, will receive $105.00 per day for hospitals that do not provide obstetrical care and $142.00 per day for hospitals that do provide obstetrical care.

iii) Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviation above the

Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.

iv) Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.

B) Hospitals qualifying under subsection (c)(1)(A) of this Section will also receive the following rates:

i) County owned hospitals as defined in Section 148.25 with more than 30,000 Total days will have their rate increased by $455.00 per day.

ii) Hospitals that are not county owned with more than 30,000 Total days will have their rate increased by $330.00 per day.

iii) Hospitals with more than 80,000 Total days will have their rate increased by an additional $423.00 per day.

iv) Hospitals with more than 4,500 Obstetrical days will have their rate increased by $101.00 per day.

v) Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional $194.00 per day.

vi) Hospitals with an MIUR greater than 74 percent will have their rate increased by $147.00 per day.

vii) Hospitals with an average length of stay less than 3.9 days will have their rate increased by $41.00 per day.

viii) Hospitals with an MIUR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999, will have their rate increased by $227.00 per day.

ix) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an average length of stay less than four days will have their rate increased by $182.25 per day.

x) Hospitals receiving payments under subsection (c)(2)(A)(ii) of this Section that have an MIUR greater than 60 percent will have their rate increased by $281.00 ~~$202.00~~ per day.

xi) Hospitals receiving payments under subsection (c)(2)(A)(iv) of this Section that have an MIUR greater than 70 percent and have more than 20,000 days will have their rate increased by $98.00 per day.

C) Hospitals qualifying under subsection (c)(1)(B) of this Section will receive the following rates:

i) Qualifying hospitals will receive a rate of $421.00 per day.

ii) Qualifying hospitals with more than 1,500 Obstetrical days will have their rate increased by $369.00 per day.

D) Hospitals qualifying under subsection (c)(1)(C) of this Section will receive the following rates:

i) Hospitals will receive a rate of $28.00 per day.

ii) Hospitals located in Illinois and outside of HSA 6 that have an MIUR greater than 60 percent will have their rate increased by $55.00 per day.

iii) Hospitals located in Illinois and inside HSA 6 that have an MIUR greater than 80 percent will have their rate increased by $573.00 per day.

iv) Hospitals that are not located in Illinois that have an MIUR greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have fewer than 4,000 Total days; or $246.00 per day for hospitals that have more than 4,000 Total days but fewer than 8,000 Total days; or $178.00 per day for hospitals that have more than 8,000 Total days.

v) Hospitals with more than 3,200 Total admissions will have their rate increased by $248.00 per day.

E) Hospitals qualifying under subsection (c)(1)(D) of this Section will receive the following rates:

i) Hospitals will receive a rate of $41.00 per day.

ii) Hospitals with an MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.

iii) Hospitals with an MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $87.00 per day.

iv) Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rate increased by an additional $41.00 per day.

F) Hospitals qualifying under subsection (c)(1)(E) of this Section will receive $188.00 per day.

G) Hospitals qualifying under subsection (c)(1)(F) of this Section will receive a rate of $55.00 per day.

H) Hospitals that qualify under subsection (c)(1)(G) of this Section will receive the following rates:

i) Hospitals with an MIUR greater than 19.75 percent will receive a rate of $69.00 per day.

ii) Hospitals with an MIUR equal to or less than 19.75 percent will receive a rate of $11.00 per day.

I) Hospitals qualifying under subsection (c)(1)(H) of this Section will receive a rate of $268.00 per day.

J) Hospitals that qualify under subsection (c)(1)(A)(iii) of this Section will have their rates multiplied by a factor of two. The payments calculated under this Section to hospitals that qualify under subsection (c)(1)(A)(iii) of this Section may be adjusted by the Department to ensure compliance with aggregate and hospital specific federal payment limitations. A portion of the payments calculated under this Section may be classified as disproportionate share adjustments for hospitals qualifying under subsection (c)(1)(A)(iii) of this Section.

3) DHA Payments

A) Payments under this subsection (c) will be made at least quarterly, beginning with the quarter ending December 31, 1999.

B) Payment rates will be multiplied by the Total days.

C) Total Payment Adjustments

i) For the CHAP rate period occurring in State fiscal year 2004, total payments will equal the methodologies described in subsection (c)(2) of this Section. For the period April 1, 2004, to June 30, 2004, payment will equal the State fiscal year 2004 amount less the amount the hospital received under DHA for the quarters ending September 30, 2003, December 31, 2003, and March 31, 2004.

ii) For CHAP rate periods occurring after State fiscal year 2004, total payments will equal the methodologies described in subsection (c)(2) of this Section.

d) Rural Critical Hospital Adjustment Payments (RCHAP)
RCHAP shall be made to rural hospitals, as described in 89 Ill. Adm. Code 140.80(j)(1), for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 per year. The Department shall also make an RCHAP to hospitals qualifying under this subsection at a rate that is the greater of:

1) the product of $1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or

2) the product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

e) Total CHAP Adjustments
Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in subsections (a), (b), (c) and (d) of this Section. The critical hospital adjustment payments shall be paid at least quarterly.

f) Critical Hospital Adjustment Limitations
Hospitals that qualify for trauma center adjustments under subsection (a) of this Section shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in subsection (a)(1) of this Section, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) of this Section. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.

g) Critical Hospital Adjustment Payment Definitions
The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

1) "Alzheimer days" means total paid days contained in the Department's paid claims database with a ICD-9-CM diagnosis code of 331.0 for dates

of service occurring in State fiscal year 2001 and adjudicated through June 30, 2002.

2) "CHAP base period" means State Fiscal Year 1994 for CHAP calculated for the July 1, 1995, CHAP rate period; State Fiscal Year 1995 for CHAP calculated for the July 1, 1996, CHAP rate period; etc.

3) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.

4) "Combined MIUR" means the sum of Medicaid Inpatient Utilization Rate (MIUR) as of July 1, 1999, and as defined in Section 148.120(k)(5), plus the Medicaid obstetrical inpatient utilization rate, as described in Section 148.120(k)(6), as of July 1, 1999.

5) "Medicaid general care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

6) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

7) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (g)(5) of this Section.

8) "Medicaid obstetrical care admission" means hospital inpatient admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with Diagnosis Related Grouping (DRG) of 370 through 375; and specifically excludes Medicare/Medicaid crossover claims.

9) "Medicaid trauma admission" means those claims billed as admissions that were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99.

10) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.

11) "RCHAP general care admissions" means Medicaid General Care Admissions, as defined in subsection (g)(4) of this Section, less RCHAP Obstetrical Care Admissions, occurring in the CHAP base period.

12) "RCHAP obstetrical care admissions" means Medicaid Obstetrical Care Admissions, as defined in subsection (g)(7) of this Section, with a Diagnosis Related Grouping (DRG) of 370 through 375, occurring in the CHAP base period.

13) "Total admissions" means total paid admissions contained in the Department's paid claims database, including obstetrical admissions multiplied by two and excluding Medicare crossover admissions, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

14) "Total days" means total paid days contained in the Department's paid claims database, including obstetrical days multiplied by two and excluding Medicare crossover days, for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999.

15) "Total obstetrical days" means hospital inpatient days for dates of service occurring in State fiscal year 1998 and adjudicated through June 30, 1999, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; V27 through V27.9; V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

(Source: Amended at 29 Ill. Reg. _____, effective _____)